OCCUPATIONAL THERAPISTS: EMPOWERORS OR OPPRESSORS?

A STUDY OF OCCUPATIONAL THERAPY STUDENTS' ATTITUDES TOWARDS DISABLED PEOPLE

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ABSTRACT

The aim of the research was to investigate the concepts of, and attitudes towards, people with physical disabilities held by occupational therapy (OT) students, so that a theory of professional attitudes and professional action could be developed. The research was building on previous research by the author, which found that OT students tended to have a maternalistic and nurturing view of disabled people, and also as a response to issues raised by the social model of disability which questioned whether OT was an oppressive or empowering profession. Utilising an integrated methodology, the research sought to address the following research questions:

what, amongst OT students, is a 'professional' attitude towards disabled people?

are the attitudes of OT students towards disabled people any different from those of other students?

do these attitudes change over time?

are there any differences in the 'personal' and 'professional' attitudes of OT students towards disabled people?

how accepting of disabled people are OT students, would they be willing to work with disabled people as colleagues?

is there an hierarchy of relationships for people with different impairments?

what does the 'professional' attitude mean in practice?

how does this 'professional' attitude develop?

what factors influence its development?

does contact with disabled people have any effect on attitudes?

do OT students express attitudes and values which oppress or empower their disabled clients?

A case study approach was used with a variety of data collection methods. The main focus of the study was the collection of data, using a questionnaire and a series of interviews, from a cohort of OT students throughout the 3 years of their OT degree. The questionnaire included the Attitudes Towards Disabled People Scale, a suitability for OT training scale, and a semantic differential exploring stereotypes of disabled people. Data were also collected from other groups of OT students comparing personal and professional attitudes and attitudes in terms of social distance, using the Disability Social Distance Scale. Comparative data was collected from non-OT students. In order to explore attitudes in greater depth a small group of students was selected from the main OT cohort and interviewed about their attitudes and approaches to disabled people at 3 points during their studies. Analysis of the data revealed that the OT students held highly positive personal and professional attitudes towards disabled people. These attitudes were also demonstrated by the use of an empowering, client-centred approach to OT interventions. However, the OT students had a tendency to focus on an individualistic and personal tragedy approach to disability. This individualistic approach might result in oppressive practice. The findings were used to develop a conceptual framework for OT interventions with disabled people which should allow therapists to articulate and develop their practice within an empowering framework.

Chapter 1

INTRODUCTION

The aim of this research was to investigate the concepts of, and attitudes towards, people with physical disabilities held by occupational therapy [OT] students, and to explore how these change throughout professional socialisation. The key issues to be addressed by this investigation of attitudes towards disabled people were:

Whether the concepts and attitudes of OT students were different from those held by non-OT students, and thus whether specific 'professional' concepts and attitudes could be described;

How far the concepts and attitudes of OT students might be seen to enable empowerment by allowing choice and control to be vested in the client;

Or

Whether the essential focus of the concepts and attitudes were oppressive, because disabled people were viewed as less than or different from non-disabled people and the attitudes expressed maintained the power imbalance between professional and client by reducing choice and control for the client.

By investigating the development of professional attitudes in one domain it was hoped to be able to develop a model of attitude change during professional socialisation and to develop guidelines for professional education to facilitate the development of professional attitudes during training for health and social care professions. The reasons for the choice of

this research focus were two-fold, to build on the findings of previous research (Taylor, 1990) and to reflect changes in the philosophy and practice of OT.

Research undertaken by the author as part of the MA in Sociological Research in Health Care (Taylor 1990) looked at concepts of health, illness and disability held by OT students and OTs and how these change throughout the professional socialisation process. The analysis of the concepts of disability revealed a rather 'maternalistic' view especially amongst 1st year students. Maternalistic, here, is used to indicate expressions of wanting to care for and look after disabled people and to imply making decisions on behalf of the disabled person rather then facilitating the disabled person to make the decision, and thinking of disabled people as 'brave' and as 'striving to be normal'. This view appeared to diminish as the student finished training and moved into the world of clinical work. A nice example of this, from a piece of coursework from a first year student, illustrates this rather well. As part of an introductory module on the sociology of disability, students are asked to talk to someone who is disabled, and then to write an essay, which interweaves theory with the experience of disability. This is an example of someone talking about a man with a mental health problem, although I should add, in fairness to most of the students, this is a very poor essay, but it does illustrate a common theme:

> *He struggled to be accepted as normal, but received a lot of stigma and rejection in the process. After spending 2 years in hospital, he emerged, determined to be accepted in society. He applied for a job,*

clarifying from the beginning that he had a history of mental disorder. Despite this they employed him, but after just 6 weeks got permission from the appropriate authorities to dismiss him.

Also after that last prolonged breakdown during which he achieved the almost impossible, during which he adopted a positive attitude to face the world and become accepted, his family rejected him. His own wife and kids did not want him back. He carried on though, a model to all, facing milestone after milestone - surmounting them and continuing with his struggle to lead a 'normal life'.

This is a very extreme example, but the notion of 'caring' for the person and helping the individual to strive for normality and independence in daily living tasks was common, although it did diminish as training progressed. But does this notion of caring really exist and does it change and diminish as the training progresses, and if it does change how does it change, do the students stay focused on normality and independence as the goal? This research hoped to address some, if not all of these questions.

If the concepts of disability expressed by OT students are of disabled people as 'brave', 'suffering' and 'wanting to be normal', then this will impact on their practice as therapists. Based on these concepts their practice will be oppressive in that it will remove choice and power from the disabled client by assuming that her/his goal is 'normality' and, therefore, functioning independently. As will be discussed in later chapters the issue of what 'independence' means is at the heart of the conflict between disabled people

and therapists, and at the heart of whether rehabilitation (and, therefore, occupational therapy) is, inherently, oppressive.

By assuming that disabled people are striving to be normal, the therapist implies an underlying concept that disabled people are not, in fact, normal but hold a deviant status. As we shall see in later chapters, these are the dominant images of disabled people in society today and the students might, simply, be reflecting these images. What this research hoped to explore was whether this was the case or whether the concepts and attitudes students hold were changed in any way by being socialised into the profession of occupational therapy.

The second reason for the study was to do with changes in the philosophy and practice of OT. With the development of care in the community, there has been a growth of OT services within social services departments. This, together with, the rise of the Disability Movement and the growth of Independent Living schemes, has led to the growing adoption of a social model rather than a medical model approach within OT as a profession and a discussion of the philosophy and practice of the profession. It seemed the appropriate time to explore whether these ideas were impinging on the thinking of the students in training and to attempt to develop a theory of professional attitudes and professional action.

The development of the social model of disability and the growing understanding of disability as a social rather than a personal issue will be

explored in chapter 2. Here the notion of oppression and empowerment will be outlined in some detail. The values of occupational therapy and, in particular, the development of the notion of 'client-centred' practice within OT (CAOT, 1991) and of OT as enabling empowerment will be discussed in chapter 3. Townsend (1993:176) argues that OT has a philosophy and a vision of social justice, which enables individuals to 'participate as valued members of society despite diverse or limited occupational potential'. This, together with Law's (1991) recognition that OT should change the environment as well as focus on the individual, is at the heart of empowerment, which this research sought to explore.

The ideas of professional attitudes and professional actions draw on the work of Burrell and Morgan (1979) and on research into the effects of attitudes on the recipients of rehabilitation. McDaniel (1976) maintains that the attitudes held by health care professionals are probably the most important factor in determining an individual's response to treatment, and Yuker (1976) argued not only that people holding negative attitudes towards disabled people should be prevented from entering the caring professions, but also that whatever the attitudes, education should address and influence attitudes towards disabled people. Specific to OT, Benham (1988) has argued that all candidates for OT training should be screened for positive attitudes towards disabled people prior to admission to OT school. So it seemed reasonable to explore what the attitudes of a group of new undergraduate OT students were and to follow those students throughout their 3 year course and professional

socialisation and, possibly, into the real world of work, to see if their attitudes change.

By focusing on the concepts and attitudes of OT students towards disabled people, this research hoped to explore the meanings and perceptions, which underpin professional actions, thus locating this research within a symbolic interactionist perspective. By gaining an understanding of the meaning of disability for OT students through their concepts of and attitudes towards disabled people, it should be possible to conceptualise the professional actions of OTs working with physically disabled clients. This research takes place within the context of the professional socialisation of a group of OT students. Professional socialisation is the process by which the neophyte therapist becomes an OT. She learns the theories underpinning OT and the professional attitudes and behaviour that are part of being an OT. The goals of any OT education are to teach the knowledge, skills and *attitudes* necessary for professional practice as an OT. The theoretical themes, which underpin the research, are those of oppression and empowerment. These themes are drawn together and conceptualised within a model of social theory outlined by Burrell and Morgan (1979). The model will evolve and be refined as the thesis unfolds, to facilitate the development of a model of OT practice. This model (Burrell and Morgan, 1979) was chosen as a basis for the conceptual framework as, when the research was beginning, it appeared to be a useful conceptual model of social theory, having been used previously in the analysis of both social work (Whittington and Holland, 1985) and psychology (Holland, 1991) practice.

Burrell and Morgan (1979) identified four paradigms of social theory: functionalist; interpretive; radical humanist; and radical structuralist, which are differentiated by their location on two axes. The two axes are assumptions of the nature of social science (subjective and objective) and assumptions about the nature of society (sociology of regulation and sociology of radical change). Each paradigm creates a 'frame of reference, mode of theorising and *modus operandi* of the social theorists who operate within them' (Burrell & Morgan, 1979:23).

These two axes (or dimensions) and four paradigms together provide a 'map for negotiating the subject area' (Burrell & Morgan, 1979:24) of social theory, a way of conceptualising or organising the various assumptions about the nature of society and the nature of social science/theory. Each paradigm encompasses a specific set of assumptions about the nature of social reality and a particular way of viewing the world. The four paradigms together provide pegs to hang ideas and places to locate assumptions and can be used to assist the novice researcher and theorist in conceptualising the variety of views of her particular social (research) world. As Burrell and Morgan propose, the four paradigms can provide a map to help the researcher to see 'where you are, where you have been and where it is possible to go in the future' (Burrell & Morgan, 1979:24).

The first dimension (and, therefore, the first axis of the map) identifies the philosophy of science upon which all theories are based. One end of the dimension is the subjective philosophy which views reality (ontology) as 'the

product of individual consciousness' (Burrell & Morgan, 1979:1), whilst knowledge (epistemology) is based on 'experience and insight of a unique and essentially personal nature' (Burrell & Morgan, 1979:1-2). Human nature, from a subjective view, is focused on free will 'where man *(sic)* is regarded as the creator of his *(sic)* environment' (Burrell & Morgan, 1979:2). At the other end of this dimension is the objective view of science. This sees reality as external to the individual. This view leads to an epistemological premise where knowledge is based on 'facts' and where it is possible to identify what is 'true' and what is 'false'. Human nature, in the objective view, is the product of the environment and of experience, 'humans are conditioned by their external circumstances (Burrell & Morgan, 1979:2). This is one dimension (or axis) of Burrell and Morgan's map:

subjective ——————————— *objective*

understanding	*cause*
personal experience	*evidence*
internal view	*external view*

The second dimension is based on assumptions about the nature of society, with theories of radical change at one end and theories of regulation at the other:

radical change——————————— *regulation*

conflict	*order*
change	*stability*
coercion & power	*consensus*
deprivation & oppression	*status quo*

Theories of regulation assume that there is an underlying cohesiveness and unity within society, the rules, objectives and roles within society are agreed and based on consensus. A major goal is to maintain the integrity of society

and so people who are outside the norm (i.e. deviant) must be integrated or reintegrated into society. Theories of radical change are in sharp contrast to those of regulation. The central premise of theories of radical change is that society is characterised by structural conflicts and domination of one group by another, more powerful, group. Rather than integration, the goal is for emancipation and the radical restructuring of society.

The two dimensions (subjective – objective, radical change – regulation) have been used as horizontal and vertical axes to create a map of four theoretical paradigms. Thus, underlying assumptions of objectivity and regulation give the functionalist paradigm; subjectivity and regulation give the interpretive paradigm; subjectivity and radical change give the radical humanist paradigm and objectivity and radical change give the radical structuralist paradigm. Together giving a framework for theory.

These paradigms have also been used to demonstrate ways of thinking, and theorising, within the professional practice of social work and clinical psychology (Holland, 1991, Whittington and Holland, 1985). Whittington and Holland (1985) used Burrell and Morgan's model in exactly the way that the authors proposed, as a map to provide a framework for theory. In Whittington and Holland's case it was to provide a framework to develop four paradigms of social work theory. Each social work paradigm outlines the core view of society, the perceived sources of social problems and the aims of social work pertinent to that paradigm. Whittington and Holland proposed that their

framework could be used as both a teaching and an analytical tool for the enhancement and development of social work theory and practice.

Holland (1991) used Burrell and Morgan's framework in a more practical manner within a clinical psychology perspective. Holland (1991: 59) proposed that the four paradigms could be viewed as models of intervention which could 'frame the psychic and social change', for a client with mental health problems, as the client moves from passive patient (or victim) within the functionalist (or medical) model to challenging the oppressions within society and identifying the need for radical social action and change. The paradigms become, therefore, both a framework for theory and a model for practice, which is empowering and emancipatory.

These paradigms can also be used as a map to explore both the theories of disability and the practice of occupational therapy with physically disabled people. Whilst these ideas will be explored in much more detail in chapters 2 and 3, the paradigm framework and its relationship to theory and practice is illustrated in Figure 1:1 *(see p13)*.

Each paradigm encompasses a specific set of assumptions about the nature of social reality and as such can be used as a map and a tool to analyse particular views of disability which are based on specific assumptions about disability and the way disabled people should be 'dealt with'. Each dimension can be expanded to explore issues of disability. The subjective – objective axis highlights the contrasts between the focus on the subjective experience

of disability where the focus is on the meaning of disability for the individual and the objective reality of disability, the symptoms of impairment and the inequalities faced by disabled people as a group. The regulation – radical change axis highlights the differing views of disability as a personal tragedy or a social phenomenon with the central themes for this thesis of oppression and empowerment. This axis also highlights the different theoretical views of medical sociologists, who tend to concentrate on the individual experience of disability (e.g. Locker, 1983, Robinson, 1988, Wiener,1975) and the disability theorists who draw on feminist and racism theory and research to explore the disability experience (e.g. Abberley, 1987, Morris, 1996).

In terms of thinking about both disability and OT practice, each paradigm can be elaborated by three elements:

causes of disability;

the focus of intervention;

the goal of intervention.

The different paradigms can be seen as representing the following models:

functionalist:

the medical model, with its focus on dealing with the symptoms of impairment;

causes of disability – physical cause, specific pathology

focus of intervention – the causes and symptoms of impairment

goal of intervention – cure, return to normality, reintegration into society

interpretive:

the rehabilitation model, which is still dealing with the symptoms and 'problems' of the impairment, but focusing on the individual who has those symptoms, and how activities can be adapted to help the individual to overcome the problems caused by her/his impairment;

causes of disability – as medical model

focus of intervention – adapting and changing the individual to deal with impairment

goal of intervention – normal function, independence, reintegration in society

radical humanist:

the independent living model, where the focus is on the client having control over the process of intervention and sharing her/his experience with other disabled people;

causes of disability – physical and social barriers

focus of intervention – control over the environment, sharing of experiences

goal of intervention – acceptance by society

radical structuralist:

the social model of disability, where the focus is on social action and changing society to suit the needs of the disabled person rather than helping the disabled individual to deal with the problems that society creates.

causes of disability – societal attitudes and oppression

focus of intervention – social action

goal of intervention – removing barriers, changing society.

Figure 1:1: Paradigms of theory and practice

radical change

radical humanist **independent living** shared meanings	*radical structuralist* **social model** action and change
rehabilitation model meanings understanding *interpretive*	**medical model** symptoms *functionalist*

subjective — **objective**

regulation

Based on: Burrell & Morgan (1979), Whittington & Holland (1985) & Holland (1991)

All of these paradigms/models can be used within the practice of OT. Occupational therapy is currently an emerging academic discipline (Ottenbacher, 1996, Kielhofner, 1997). It is beginning to develop its own knowledge base and theory. Whilst some of this knowledge base is being

drawn from the new academic field of occupational science, much of the knowledge base of occupational therapy is drawn from other academic disciplines, for example medicine, psychology, biomechanics, anthropology and sociology. Ottenbacher (1996:330) argues that 'the knowledge base associated with an academic discipline provides a map for professional development'. Burrell and Morgan's paradigms have also been described as a map, and as such can help to articulate and identify key areas on the map of professional development and practice for OTs working with physically disabled clients. Without the ability to clearly articulate the ideas, from other academic disciplines, which underpin the various conceptual practice models' (Kielhofner, 1997:23) of occupational therapy, the practice of OT apprears to be based on nothing more than 'common sense'. Using Burrell and Morgan's paradigms as a tool to help articulate the underpinning assumptions of the models of disability and of occupational therapy will help the researcher, and future OT students, to understand the 'related knowledge' (Kielhofner, 1997:25) which supports the knowledge and practice of OT.

The focus of this study was to explore whether the trainee OT develops her thinking from a functional/medical/caring model to something more radical. Whilst the four paradigms are mutually exclusive, an individual might work sequentially through each paradigm at different times (Burrell and Morgan, 1979) or at different stages of treatment/intervention (Holland, 1991).

Burrell and Morgan's framework allows the researcher to unpack and explore the assumptions of the various models of disability. It allows the researcher to

explore the assumptions of various occupational therapy conceptual practice models and to locate them within theoretical paradigms. These theoretical paradigms are accepted in academic worlds beyond occupational therapy and, therefore, provide a common analytical base and allow ideas to be explored in language understood in a range of theoretical settings.

Whilst Burrell and Morgan's (1979) typology provides an heuristic framework for the analysis of professional attitudes and professional actions, the theoretical context of this study is based firmly within the concept of disability as oppression. Oppression can be defined as

> *oppress*: keep in subservience by coercion; govern or treat harshly or with cruel injustice ...
>
> *oppression*: the act or an instance of oppression (Allen, 1990: p832).

The key themes, which emerge from the definition above, are subservience and injustice. We appear to have a process of keeping a group of people in a lower or subjugated position where there is an unequal power relationship with one more powerful group in control. Williams (1989: 254) interprets oppression as:

> the imposition of constraints; it suggests that the problem is not the result of bad luck, ignorance or prejudice, but it is caused rather by one group actively subordinating another group to its own interest

The oppression of disabled people is not just economic but attitudinal and OTs, as professionals who hold knowledge about disability and its

consequences, can be seen, as Abberley (1995) argues, as one of the groups who maintain the oppression of disabled people. However, as the philosophy of OT practice becomes more client-centred, therapists should move from oppressors to enablers, facilitators and empowerors. Empowerment can be defined as

> to give power to, or make able (Allen, 1990: 384);
>
> a process of becoming increasingly more in control of oneself and one's life, and thus increasingly more independent (Fenton & Hughes, 1989: 11).

This research aimed to explore how far that move takes place, in terms of the professional education of potential therapists.

This research was carried out within one educational context with one cohort of students. It would, therefore, seem appropriate to introduce and outline that educational context. The institution where this research was conducted was the School of Occupational Therapy (now part of the School of Health Care), Oxford Brookes University. The students who entered the BSc (Hons) in Occupational Therapy in September 1992 formed the cohort who were the focus of this study.

Occupational therapy has been variously defined as:

> The treatment of people with physical and psychiatric illness or disability through specific selected occupation for the purpose of enabling individuals to reach their maximum level of function and independence in all aspects of life. The occupational therapist

assesses the physical, psychological and social functions of the individual, identifies areas of dysfunction and involves the individual in a structured programme of activity to overcome disability. The activities selected will relate to the consumer's personal, social, cultural and economic needs and will reflect the environmental factors, which govern his/her lifestyle (College of Occupational Therapists, 1993);

the treatment of physical and psychiatric conditions through specific activities in order to help people reach their maximum level of function and independence in all aspects of daily life (World Federation of Occupational Therapists, cited in College of Occupational Therapists, 1993);

and that

> occupational therapists assess and treat people using purposeful activity to prevent disability and develop independent function (Committee of Occupational Therapists for the European Communities, cited in College of Occupational Therapists, 1993).

The issue of independence, which forms a central tenet of these definitions, will be explored in more detail both in the OT literature and within this study.

The BSc (Hons) in OT is a 3-year modular course. The course is made up of a mixture of School-based and practice-based modules. The students spend 3 terms on Fieldwork Placement, one term per academic year. On Fieldwork they are expected to work, under supervision, as OTs. Whilst on placement students will meet, interact with, and treat disabled people. It is the treatment focus that will mean that there will be a power imbalance between the student

and the disabled person, because of the nature of the patient/therapist relationship. This power imbalance, and the institutional structures that support it, may be crucial in preventing the students from adopting a more empowering philosophy of practice. During the remaining 6 terms the students are studying School-based modules and developing their theoretical understanding of practice. *(See Appendix I for more details of the course structure).*

The following 3 chapters will outline and discuss the theoretical and empirical background to this research in terms of the concept of disability as oppression and the sociology of disability; attitudes to disability; professional issues within OT. These chapters will explore and develop the meanings of oppression and empowerment in relation to OT, and the ways these meanings are expressed in attitudes will be discussed. This will provide the basis for the analysis and interpretation of the findings of this research. The methodology of the study will then be discussed and the reasons for the choice of an integrated methodology with mixed qualitative and quantitative data collection methods explored. The quantitative and qualitative findings will be presented in separate chapters. The findings and implications of the research will then be drawn together and discussed in the light of the previous research, conclusions will be drawn and their implications outlined.

Chapter 2

DISABILITY AS OPPRESSION

This chapter will explore issues pertinent to disability and sociology. The chapter will begin by exploring the idea that disability is socially constructed from the biological differences between disabled and non-disabled people. The chapter will then explore, what Oliver (1986) has called, the 'personal tragedy' ideas of disability and compare these to the social model notions of disability and the issues surrounding disability. The feminist perspective on disability will be explored; this will also draw notions of 'the body' into our discussion of disability. The chapter will then review the place of rehabilitation in the oppression of disabled people, drawing particularly on notions of normalisation and empowerment. The chapter will conclude by locating these various ideas within the models of disability, and theoretical paradigms, discussed in the Introduction.

Barton (1996) argues that mainstream sociology has shown little interest in the issues of disability, tending rather to accept the notion that disability is a medical and psychological issue and not a sociological concern. The problem rests with the individual rather than within society. However disabled (predominantly) sociologists have contributed to the generation of a social theory of disability and the understanding of the social construction of disability (Oliver, 1990, Abberley, 1987, Barnes, 1991). The notion that disability is a social construction means that rather than seeing the restrictions experienced by disabled people within the context, and as a result of, their medical symptoms or as problems of the disabled individual, any

restrictions should be seen as problems and restrictions caused by society. This perspective sees disability as a form of oppression with inherent social restrictions:

> All disabled people experience disability as social restriction whether these restrictions occur as a consequence of inaccessible built environments, questionable notions of intelligence and social competence, the inability of the general public to use sign language, the lack of reading material in Braille or hostile public attitudes to people with non-visible disabilities. (Oliver, 1991: *xiv*)

From this perspective, the only way to understand and change the restrictions and oppression experienced by disabled people is through radical change. However, before we can fully understand this perspective it is necessary to explore the images of disabled people held by non-disabled people. By exploring these images we can begin to understand the social construction and social creation of disability.

Oliver (1990) argues that the essential difference between social construction and social creation is in the location of the 'problem', in this case the oppression of disabled people. For the social constructionist, the perspective is that of the symbolic interactionist where the oppression is situated in the perceptions, actions and reactions of the non-disabled majority, either individually or collectively. For the social creationist, the Marxist perspective is more relevant and the oppression of disabled people is located within the institutions and the institutionalised practices of society. Thus, to understand fully the oppression of disabled people, we must explore the range of

possible locations of the problems of disabled people, from the social constructionist, through the disabled individual to the social creationist views. Through this we can explore the power of the medical and social care professions and the outcomes of this power in the lives of disabled people, in terms of disempowerment, dependency and oppression. Having done this it should be possible to explore the place of OT within the oppression of disabled people.

Disability as a social construct

Disabled people are different from non-disabled people, they may look different, they may move differently, they may act differently. Whatever the cause, they are perceived to be different and, therefore, must be dealt with differently. It is the task here to explore the causes and effects of these views. To investigate the social construction of disability and to see how these constructs might impact on the views of the student OT.

Safilios-Rothschild (1970: 4) proposes that

> in no time or place in the past - and perhaps in the future as well - have the disabled not been either positively or negatively discriminated against in one or more areas.

This discrimination, she goes on to argue, has two types: barring disabled people from the full range of job options available to non-disabled people; and, not allowing disabled people to integrate fully within 'normal' social interactions. Disabled people are different, and must, therefore, be treated differently. However, disabled people are not treated differently as in

celebrating the rich diversity of society (Barton, 1996), but as people who break the rules, who are not 'normal' and, therefore, must be controlled, dominated and disempowered, in other words, oppressed.

Definitions of disability

Perhaps the first place to start in the exploration of the social construction of disability is by looking at the word 'disability' and exploring its many and various definitions. Although, as Blaxter (1975) and French (1992a) argue, because disability can be viewed from a wide variety of perspectives, there can be no simple definition of disability. Definitions of disability are, however, vital. Since as Wendell (1996) argues, definitions affect an individual's self-identity, her/his interactions with family and friends, her/his political identity as well as her/his access to economic and social support services. As Bogdan and Taylor (1989: 76) state

> words - labels and names - structure how we think about and act towards others. Labels like 'retarded' have a dramatic effect on those who use them as well as on those to whom they are applied. They direct our attention to specific aspects of designated people.

Bogdan and Taylor use the term 'retarded' to illustrate this point, the term 'disabled', it will be argued, has a similar effect. A dictionary definition of disability is

> physical incapacity, either congenital or caused by injury, disease, etc.; a lack of some asset, quality or attribute, that prevent one's doing something; a legal disqualification (Allen, 1990: 331).

But this definition does not really imply discrimination or the consequences of disability. If, however, we turn to the thesaurus a much clearer picture of the negative implications of disability can be seen:

> *disability:* affliction, ailment, complaint, defect, disablement, disorder, handicap, impairment, infirmity, malady, disqualification, impotency, inability, incapacity, incompetency, unfitness, weakness;
>
> *disable:* cripple, damage, debilitate, enfeeble, hamstring, handicap, immobilize, impair, incapacitate, paralyse, put out of action, render *hors de combat*, render inoperative, unfit, unman, weaken, disenable, disqualify, invalidate, render *or* declare incapable;
>
> and
>
> *disabled:* bedridden, crippled, handicapped, incapacitated, infirm, lame, maimed, mangled, mutilated, paralysed, wreck, weakened, wrecked (McLeod, 1984: 173).

The negative and disadvantaged consequences of disability become clearer with the inclusion of words such as weak, unfit, disqualify and invalidate.

In an attempt to clarify the personal and social consequences of disease and disability, the WHO in 1980 attempted to provide a classification system. They proposed a three-fold definition of the consequences of illness, beginning with the physical and personal consequences and moving on to the consequences due to society. They proposed:

impairment: any loss or abnormality of psychological, physiological, or anatomical structure or function;

disability: any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being;

handicap: a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual (World Health Organisation, 1980: 27-29).

Within this definition it is handicap which is about the social consequences of disability and the disadvantages that might accrue. However, the disadvantage is within the individual and there is no real focus on the disadvantage and oppression which society inflicts upon the disabled individual. The emphasis is on what is considered to be 'normal', but the concept of normality and what could be defined as normal has never been explored or established.

The WHO are currently revising the definitions of impairment, disability and handicap in an attempt to redress the balance and to include, within the definitions, an acknowledgement and recognition of the limitations imposed upon disabled people by social, cultural and environmental factors (ICIDH-2, http: //www.who.int/msa/mnh/ems/icidh/introduction). However Pfeiffer (1998) argues that the revisions in ICIDH-2 continue to focus on issues of normality and that they are

> tied to Western, middle class concepts of what is and what is not normal in terms of human behaviour. Behaviour which is not normal is considered to be bad and to stigmatize the individual as a person with a disability. (Pfeiffer, 1998: 513)

Fougeyrollas, Noreau and Boschen (1998), with the Canadian Society on ICIDH, have proposed an alternative model – the Handicap Creation Process. This model, whilst acknowledging personal factors in the handicap process also highlights environmental factors which can handicap the individual. They also propose the notion of 'social participation', which, as the result of the interaction of individual and environmental factors may also handicap the individual and restrict her/his participation in society. This model acknowledges, and provides a tool for measuring, the impact of societal attitudes on the behaviour of the individual. It remains to be seen whether WHO will incorporate these ideas into ICIDH-2.

The WHO definition of disability falls into the category of administrative definitions (French, 1992a, Finkelstein, 1991, Blaxter, 1975, Wendell, 1996). Administrative definitions serve to facilitate legislation and the planning of services and as such tend to be rigid and dichotomous (Blaxter, 1975, French, 1992a),

> whereas capacities and limitations must form a continuum, any point at which the dichotomy is established must be arbitrary, and moreover only temporary, depending on technological and policy factors (Blaxter, 1975: 211).

French (1992a: 215) highlights the example of being registered as blind or partially sighted which may depend more

> on the doctor's and the disabled person's attitudes towards blindness and their ability and willingness to negotiate with each other,

as on any clear-cut legal definition. So, even a legal definition has a social element. Thus, disability is more than the physical impairments, it has a social component, which is probably more significant than the physical limitations and problems caused by the impairment (Blaxter, 1975). By exploring with the OT student cohort their definitions of disability, it should be possible to highlight whether they see disability as a social construction or an individual problem.

Perceptions of disability

Definitions can help to classify and identify what might be seen as disability. But one of the major issues with the term 'disability' is that once a person is identified as disabled s/he becomes only seen as disabled, any other strengths or weaknesses s/he might have becomes subsumed within the label of disability. The fact that someone is disabled skews our perceptions of her/him, disability becomes a master status (Goffman, 1968).

> By turning a description of a condition into a description of people, we are saying that this is all we really need to know about them. We confirm their 'abnormality'. (Shearer, 1981: 3)

Taking a social constructionist view, the label and master status of disability then allows us to make assumptions about the disabled person based, in part, on common perceptions and stereotypes of disability. These

perceptions, assumptions and stereotypes form the cultural construction (Wendell, 1996) of disability. By looking at current and common historical perceptions of disability we can begin to explore where these ideas about disabled people come from, how these ideas help to construct societal notions of disability and the effects of these different perceptions on the ways in which disabled people are treated or dealt with, the effects of cultural images on the oppression of disabled people (Barnes, 1996), and, therefore, the images, assumptions and stereotypes that OT students might have of disabled people. Kurtz (1981), drawing on the work of Wolfensberger (1969), outlines 10 common perceptions of people who are mentally retarded. These perceptions can be equally well be applied to physically disabled people, as will be developed here.

Disabled people as subhuman organisms

Goffman (1968), in his work on stigma, talks of people who have 'abominations of the body' or physical disabilities and deformities and that the bearers of these marks or stigmas are seen as, more than as not quite normal, but as 'not quite human' and so they can be discriminated against and have their life chances reduced (Shearer, 1981). As Wendell (1996) points out, abominations of the body is the most powerful and negative of Goffman's 3 types of stigma. A criminal record is merely a 'blemish on the character'. Goffman is reflecting the symbolic meaning and negative cultural stereotypes of disabled people.

If disabled people are sub- or less than human they 'lack the same type of emotional and physical needs that are assumed for normal people' (Kurtz, 1981:16). The effects of this perception can clearly be seen in the contemporary ethical issues of abortion, genetic screening and counselling, withdrawal of treatment and euthanasia, and the focus of medical research into disabling conditions. Abortion is an emotive issue at the best of times, but linked to pre-natal screening for such disabling conditions as spina bifida and Down's syndrome and the issue of whether a potentially disabled child has the possibility for a 'human' life, the issue becomes explosive (Morris, 1991). Euthanasia and the withdrawal of treatment to people who are severely disabled also implies an assumption that disability equals a sub human existence. Extreme examples of this are the cases of persistent vegetative state, such as the case of the Hillsborough victim Tony Bland. Less extreme, but possibly more telling, examples include the focus of the film and play 'Whose life is it anyway?' which explores the arguments for suicide/euthanasia for a man severely disabled in a road accident whose perception of life with a disability was of no life, a life that was not worth living. These are debates and issues which have relevance for the professional socialisation of OT students as they learn about and work with clients severely disabled following head injuries and accidents.

Genetic screening and counselling, and the focus of medical research into the genetic causes of disabling conditions also begs the question of the humanity of a disabled person. Both of these activities are aiming to eradicate disability, not by 'curing' or treating it, or even by dealing with the

disabling aspects of society, but by making sure that disabled people are not born (Morris, 1991).

> What does it say about my life when the only research being done into my type of disabling condition is trying to make sure that people like me aren't born in the future. (Mace, 1995)

On a much lesser scale, the fact that disabled people are often denied access to places that non-disabled people take for granted, can also be seen as a denial of human rights. Although things are improving and many of the physical barriers to access are disappearing, it is still difficult for disabled people (especially wheelchair users) to travel by public transport. If you are disabled you cannot fly unaccompanied, and yet young children can and airlines allocate the resources to look after them. Recently a case came to light of a wheelchair user who was unable to travel from her local railway station because staffing had been reduced and she could not be accompanied from one platform to the opposite platform by two members of staff, which is what the regulations specified. The disempowerment and the lack of choice inherent in all of these examples reinforce the oppression of disabled people.

One of the central aspects of 'human-ness' is the rich and fulfilling variety of relationships, both emotional and physical, which non-disabled people take for granted. But this has not been the same for disabled people.

> In his *[sic]* encounter with society, the invalid rarely meets active dislike and disgust. But if he ventures into the world of love, such feelings are not so far off (Thunem, 1966: 50).

Shearer (1981) argues that there has been a move from the denial of the sexuality of disabled people, linked to the eternal child perception, to a growing awareness of their humanity and sexuality. However, this awareness has created a denial of the human right of privacy, for the sexual behaviour of disabled people has become public knowledge (e.g. Nosak, 1996), something that would not be seen as appropriate for other people in society. A recent example of this was the request for information, from an undergraduate OT student to an OT Internet mailbase, on sex and disabled women. Responses to this request focused solely on giving references for articles on the sexual functioning of disabled women. In this instance OTs appear to be reinforcing the 'not quite human' perception of disabled people.

In some cases disabled people are thought of as even less than animals, as vegetables. This approach is highlighted in Miller and Gwynne's (1972) study of residential care for physically disabled people. They divided the philosophies and practices of residential care settings into two groups, 'warehousing' and 'horticulture'. Both these terms appear to say more about the growing of potatoes or cabbages than about the domestic arrangements of human beings and are indicative of the philosophies of care which OT students may come across during their Fieldwork education.

Disabled people as a menace

Disability can be seen as unclean and evil or even a source of pollution or something that is catching or contaminating (Shearer, 1981). Disability is seen as evidence of possession by evil spirits, both historically and in contemporary societies. Martin Luther saw profound handicap as the work of the devil and in parts of Africa today, severely disabled children are assumed to be possessed by spirits (Shearer, 1981).

Disability as something inherently bad, a threat to the health of society and in need of control and eradication was the central tenet of social Darwinism and the Eugenics movement. These ideas began in Britain and the United States, but had their ultimate and terrifying conclusion in Nazi Germany (Morris, 1991). For the Nazis disabled people were people whose lives were not worth living, they were a drain on the economic resources of the country and should, therefore, be eradicated. The Nazi Euthanasia Programme, which was established to remove people with physical or intellectual disabilities or mental illnesses, killed over 200,000 people (Morris, 1991). This practice was not confined to Nazi Germany. In the 1920s and 1930s countries including Denmark, Norway, Sweden, Finland, Estonia, Czechoslovakia, Hungary and Turkey, and 29 American states (Morris, 1991) passed sterilisation laws to control the menace of disability.

The notion of disabled people as a menace is also implicit in what Oliver (1990: 20) calls the

> surplus population thesis ... [this] argues that in societies where economic survival is a constant struggle, any weak or dependent members who threaten their survival will be dealt with.

Disabled people as objects of pity

The fact that disabled people should be pitied is exemplified in the language we use to talk of disability. People are said to 'suffer' from MS (multiple sclerosis) or spina bifida, they are 'victims' of road accidents or strokes. The fact that someone is disabled is seen as sad and tragic, but why should it be?

> The *event* that leads to disability may be, the life that stems from it need not, for each individual will bring to it his or her own quota of individual beliefs, abilities and strengths (Shearer, 1981: 17-18).

Yet, the prevailing reaction to someone with a disability is 'how sad'. To use an anecdote to illustrate this:

> *I was in the Lake district, on holiday, with my elderly mother, and we saw a young boy, about 5 years old, with blond hair, blue eyes and a cheeky expression, coming out of a shop, and my mother said 'oh, how sad', because the young boy was in a wheelchair and very obviously had cerebral palsy.*
>
> But who is to say that that young boy's life will be any more, or less, sad than any other young boy growing up in today's world?

Unfortunately, the other side of the object of pity coin is the 'brave and courageous' image. The Handicapped Person of the Year and Children of Courage awards reinforce this image.

> The 'unfortunate' person is assumed to have wonderful and exceptional courage ... This devalues other people by implication, and leaves the fit person still with his *[sic]* original view that disablement is really utterly tragic (Hunt, 1966: 148).

The extract from the student's essay cited in the Introduction is an excellent example of the 'how sad/isn't he brave?' image.

Kurtz (1981: 18) argues that the societal response to this tragedy and sorrow is to 'attempt to bestow 'happiness' upon them, to help relieve sorrow'. Disabled people are, therefore, taken on outings to the seaside, zoo or theatre, or taken to Lourdes in search of a cure. But this 'happiness' cannot equate to what the 'normal' people do to enjoy themselves.

> If people with disabilities are 'sad', if their situation is tragic, what use have they for the ordinary pleasures of life? 'We're not meant to enjoy ourselves', says one young man ruefully (Shearer, 1981: 25).

If the disabled cannot, or should not, enjoy themselves, how much more shocking is the idea of celebrating disability and being proud of the label of disabled (Corbett, 1994). If the image of disabled people as tragic but brave is held by OT students, how well will they deal with disabled people who want to celebrate their disability and their different-ness, how empowering will their practice be?

Disabled people as eternal children

The image of the eternal child is reinforced by media representations of disabled people. The majority of images are of children, who, in fact, make up

a small percentage of disabled people, and not of people who are older or have multiple problems, which would be a much truer picture (Karpf, 1988, French, 1992a). If disabled people are eternal children, then society has no right to expect them to behave like adults, nor to expect to be treated like adults. This perception can also influence the facilities made available to disabled people and the philosophies of practice of those health and social care professionals who come into contact with disabled people.

Disabled people as burdens on charity

The perception that disabled people cannot care for themselves and should, therefore, be provided for by those more fortunate than themselves is reinforced, very powerfully, by the charities who raise money for disabled people and by events such as 'Children in Need' and telethons (Karpf, 1988). These events tug at the heartstrings and act on the guilt of the non-disabled who give because it makes them feel good and also out of gratitude at their normality. As one disabled activist put it

> fund-raising at a distance ... the twentieth-century version of the beggar in the streets. Even the begging bowls are no longer in our own hands ... [It] gives people a sense of doing something for us without bringing them into contact with us (Karpf, 1988: 88).

The perception of the burden on charity and the way it is reinforced by these fund raising events also tends to move the emphasis for provision of support and services away from the state and statutory authorities.

> Telethons (since they rarely collect for luxuries) can't help but contribute to the idea that it's the job of private organisations and not the state to provide or collect essential funds (Karpf, 1988: 88).

The images of disabled people that are portrayed by these events are also misleading and misrepresentative. Children in Need focuses, as the name implies, on children and yet the vast majority of disabled people are old, multiply handicapped and far from the cute youngster image regularly found on television.

But the perception of the disabled as burdens on charity is not unique to the charities and fund-raisers.

> The cripple is an object of Christian charity, a socio-medical problem, a stumbling nuisance, and an embarrassment to the girl he falls in love with. He is a vocation for saints, a livelihood for the manufacturers of wheelchairs, a target for busybodies, and a means by which prosperous citizens assuage their consciences (Battye, 1966: 16).

By exploring the reasons OT students give for becoming OTs it might be possible to assess whether they hold this oppressive view of disabled people needing care and looking after. As Morris (1993: 38) points out, the ideology of 'caring' within social and health care practice is interpreted as 'taking responsibility for and taking care of' disabled people. By making decisions on behalf of their clients OTs are continuing this oppressive ideology of care.

Disabled people as objects of ridicule

Ridicule might be having to be the butt end of jokes, seen as a figure of fun (Kurtz, 1981) or laughed at in the street, but it can equally be the negative stereotypes that can be attached to disability.

> No affliction generates so much ridicule, contempt and confusion as a deaf person among 'normals' ... People who are deaf are thought of as 'daft' and generally unreliable. (Shearer, 1981: 49)

Thus someone who uses a wheelchair is assumed to be 'simple' or someone who is unsteady because of MS is assumed to be drunk (Blaxter, 1976) and, therefore, the object of contempt and ridicule.

These perceptions will have their effects on the ways disabled people deal with any problems they have, irrespective of whether these problems are due to their disability. Some people will attempt to cope better than anyone else (Shearer, 1981), others reject societal expectations and choose, deliberately, to be different, to stand out from the crowd and, therefore, to throw ridicule back in the faces of the 'normals'.

Disabled people as objects of shame

If the disabled are something to be ashamed of, then they should be locked up, or at least segregated and kept out of sight, so as not to remind us (the normal) of their differentness and difficulties. Kurtz (1981: 19) talks of someone he knows of who

> traced the outline of his retarded child's foot on cardboard, taking this to the store to buy a pair of shoes so that the child would not be seen in public.

It is this author's experience, of staying with cousins in Ireland who had a severely disabled daughter, that the girl was kept in a room with her nurse, never joined the family for meals and when her howls filled the house they were totally ignored.

Shearer (1981: 7-8)) points out that these feelings of shame are not exclusive to non-disabled people. She cited a woman who has problems walking as a result of MS:

> I feel a fool and an idiot when I am walking ... I find I watch other people to see if there is any fault in their walk. When people are walking towards me, I see their eyes slide away at first, and each time I'm pleased, then angry - pleased that they care and don't want to embarrass me further, then angry that they need to look away, so I can't be attractive at all, no matter how I dress ... I also still feel uncomfortable with other disabled people, because I feel about them as I think normal people feel about me.

Disabled people as holy innocents

This is similar to the eternal child perception but includes another dimension, that of the disabled person as a special child of God (Kurtz, 1981), blessed in some way by God and so must accept her/his suffering and look on it as a blessing and an opportunity for growth. This opportunity for growth idea has

echoes in some early rehabilitation literature and will be discussed further under the 'developing person' heading. Certain religious groups perceive disabled people as 'incapable of voluntarily committing evil, and consequently they may be considered incapable of sinning' (Kurtz, 1981: 19).

Disabled people as sick

If the disabled person is sick, then s/he must go to the doctor and become a patient for her/his problems to be dealt with. More importantly, perhaps, if her/his disability is due to sickness, or a definable medical condition, then not only can it be treated, but also, it can be cured and so will cease to be a problem. This, of course, is the major flaw in the medical model; disability is not something that can be cured. The other major flaw with the medical model is that 'the problems that disabled people experience [are seen] as being a direct consequence of their disability' (Oliver, 1983: 15). These ideas link with the notion of disability as a personal tragedy, which will be discussed in more detail later on.

The fact that disabled people are seen as sick is exemplified by the term used for the hospital specialities which have been the focus of the care of disabled people: young chronic sick. The sickness, diagnosis or presenting condition e.g. paraplegia, MS, stroke, will become the focus of interest and activity. Whilst the individual who happens to be paraplegic, have MS or have had a stroke, is ignored (Albrecht, 1992, Zola, 1993).

Albrecht (1992: 85-86) has developed the medical model into an ideal type, highlighting the ways the medical model deals with and controls disability along a number of dimensions:

goals:	treat patients for illness (cure);
values:	physician in charge who knows best; patient should follow orders; science informs the doctor;
definition/ diagnosis:	the patient is sick; the doctor controls the diagnosis and orders the treatment;
aetiology:	natural causes are assumed; causes are not necessarily known;
treatment:	specific diagnosis; drugs, medical, surgical care;
prognosis:	directly related to diagnosis and complications;
function of institution:	hospital is place where doctor works on patient; this is where the doctor works;
rights and duties of the subject (client):	must play the full sick role; follow directions of doctor.

Disability has become medicalised. In some cases this is entirely appropriate, for example when diagnosing an impairment or treating an illness. However, medicine, and in particular doctors, has become involved in assessing mobility or ability to drive and deciding capacity and potential for work. Yet

> in none of these cases is it immediately obvious that medical training and qualifications make doctors the most appropriate persons to be so involved. (Oliver, 1990: 48)

The reasons for this medicalisation of disability appear to be the need to impose order within society and to use medicine as an agent of social control, particularly with regard to regulating the work force.

Albrecht (1992) talks of the disability business, of which the medical model is one framework. A number of authors, Shearer (1981), French (1992a), Oliver

(1983), Finkelstein (1980) and Albrecht (1992) included, argue that the medical model may well serve the needs of the health professionals more than it does those of the disabled person. The defining of disability as a problem that can be dealt with allows for establishing of agencies to deal with these problems. Disabled people become the *raison d'être* for the existence of professions such as OT. Without disabled people OTs would cease to have jobs.

Disabled people as developing individuals

Initially the perception that disabled people are developing individuals might seem to sit more happily with people with a mental handicap or learning disability. For, as the new name implies, people with a learning disability are, by definition, involved in an ongoing learning and developing process. But if we look at the philosophies implicit in some of the rehabilitation literature we will find the notion of the physically disabled person as someone who is growing and developing through the experience of being disabled:

> The highest stage is 'integration of disability' in which the person has developed a deeper, more lofty set of values; the disability has served to draw out of him *[sic]* great inner strength, unusual personal courage, and maturity. He now sees himself as a much better human being than he might have been had he not learned to cope with his disability, but he cherishes the great values of life that he struggled for and found. Few people go so far (Malikin & Rusalem, 1969: 23).

These ideas underpin the personal tragedy and associated rehabilitation model, which will be explored later.

It could, of course, be argued that this process of growth and adjustment is only qualitatively different from the process that everyone, disabled or non-disabled, spends their life going through.

These perceptions of disability provide a framework for the perceptions and stereotypes which non-disabled individuals hold about disabled people. They, therefore, provide a framework for the development of the research tools for this study and also for the analysis of the images of disabled people held by OT and non-OT students.

Images of disability

Biklen and Bailey (1988: *vii*) argue that

> artistic images of disability influence attitudes, behavior and public policy, [and that] disabled people are rudely stamp'd by the shadowy fantasies of the imaginal word.

So, in our exploration of the ideas, images and perceptions that underpin the social and cultural construction of disability, we must now turn to explore the images of disability and disabled people that are presented by the media. Many of the images and ideas discussed here will echo the perceptions discussed in the previous section.

When disabled people are featured on the news or in current affairs programmes or reports, the images tend to be of people in hospital or having new and revolutionary treatments (Barnes, 1994) which reinforce the perception that disability is synonymous with sickness and suffering and that

the only way to deal with it is to find a cure or for the disabled person to attempt to be normal. Recent examples of this include Cutting Edge (1996) on a new treatment for MS, which took away any symptoms that had been present for years, and Inside Story (1996) about a woman who was paralysed as the result of a road accident, who received a pioneering new electrical implant which allowed her to stand up unaided, her goal being to stand at a pub bar and drink a pint.

Karpf (1988) points out, citing American research, that the fictional images of disabled people are equally unrepresentative and distorted. In studies of TV programmes, none of the disabled characters were aged over 65, the majority were, in fact, children. They were mostly single, working class and living in institutions. They rarely appeared in crowd scenes as part of the background.

The images that disabled characters portray tend to fall into one of a number of categories: the sinister disabled; defenceless victims; the extraordinary disabled; outsiders or interesting scenery; incompetent burdens; and, pitiable, pathetic figures of pathos (Barnes, 1994, Karpf, 1988, Biklen, 1988, Diehl, 1988). The sinister, evil includes Captain Hook, Dr Strangelove, Long John Silver and Richard III. Not only are the characters disabled or scarred, their ugliness is seen to equate to evil. Even the Bible is not immune, Barnes (1994) notes that there are at least 40 instances where the idea of the cripple is linked with sin and evil. Disabled characters are also seen as easy prey and targets of violence, as in the films 'Whatever happened to baby Jane' and 'Woman in a cage' (Barnes, 1994). A common image of disabled people

is as brave and courageous. We have already discussed this in terms of the various perceptions of disability. The media reinforces these images with films such as 'My left foot' and 'Reach for the skies' and with 'super-cripple' characters such as the detective in 'A man called Ironside'. Disabled people are often included only as 'interesting scenery' (Biklen, 1988: 6). They are only there because of their disability, thus 'implicitly denying the[ir] full humanity' (Diehl, 1988: 20). People who happen to be disabled are not interviewed about their perspective on the Budget (Karpf, 1988), or are only included as a character within a soap operas because of a storyline focusing on disability, much as ethnicity or sexual orientation might be the only reason for the inclusion of a particular character. The antithesis of the image of bravery is the Mr Magoo figure of bumbling incompetence and the image of the disabled person as a burden, not just to others but to themselves, as portrayed by Clifford Chatterley in 'Lady Chatterley's lover' or in the film 'Born on the 4th of July'. The final image of disability found in the media is that of the 'figure of pathos' (Diehl, 1988: 25). Characters such as Tiny Tim in 'A Christmas carol' and Heidi's friend Clara are there to put lumps in our throats and to think 'how sad' but also 'how brave' or to serve a moral purpose or reinforce the nobility of suffering (Shearer, 1981).

On a more positive note, both Barnes (1994) and Karpf (1988) argue that things are beginning to change. There are now programmes by and for disabled people which give a more positive image and disabled people are beginning to appear in TV commercials and dramas, although more so in

America than in Britain (Karpf, 1988). However, the overwhelming image is still of a tragedy which must be dealt with by the individual.

These perceptions and images of disability are the concepts and ideologies which create the stereotypes of disabled people in our society today. Part of this research has been to explore whether OT students admit to holding any of these stereotyped images and to compare these findings to those from non-OT students.

Disability as a personal tragedy

The perceptions, images and meanings of disability within any society are a reflection of the ideologies of that society. These together with economic factors will have a profound effect on the ways disabled people are treated. The welfare state (in the UK) allows for the redistribution of the economic surplus from our capitalist economy and the ideology underpinning this, in terms of disabled people, is personal tragedy theory (Oliver, 1990, Finkelstein, 1980).

Whilst this section of this chapter draws extensively upon work which might be seen as dated (e.g. Goffman, 1968, Shearer, 1981), this reflects the nature of research into disability. It is only since the late 1980s that the view of disability as a personal tragedy has been challenged (e.g. Abberley, 1987, Oliver, 1990). The researcher felt that it was vital to the integrity of this study to draw on older as well as more recent research in order to give as thorough

an overview of the social construction of disability as personal tragedy as possible,

Perhaps the epitome of the personal tragedy model of disability, which proposes that disability is the problem of the disabled person to cope with and adjust to as successfully as s/he can, is the first official aim of the 1981 International Year of Disabled People which was 'helping disabled people in their physical and psychological adjustment to society' (cited in Shearer, 1981: 10). Oliver (1983: 15) originally wrote of the 'individual model of disability' which saw

> the problems that disabled people experience as being a direct consequence of their disability. The major task of the professional is therefore to adjust the individual to the particular disabling condition. There are two aspects of this: first there is physical adjustment through rehabilitation programmes designed to return the individual to as near normal a state as possible; and second, there is psychological adjustment which helps the individual come to terms with the physical limitations.

It was only later (Oliver, 1986: 6) that he proposed the more emotive term of 'personal tragedy theory'.

The focus of theories and research which draw on the personal tragedy, individualistic, model of disability has been on the ways disabled people cope with and adjust to the psychological aspects of disability. The central theme within any of this research is that the disabled individual must learn to accept,

and deal with, her/his status as someone who is 'not quite normal' (Goffman, 1968, Shearer, 1981) or 'inferior' (Dreikus, 1948). The ways disabled people deal with the inferiority and personal tragedy of disability can be reviewed from two perspectives: those theories which draw on psychological perspectives; and, those theories which draw on sociological perspectives. The adequacy of both these perspectives will be reviewed here as these ideas form the basis upon which the principles of rehabilitation and, therefore, OT, are based, the idea that disabled individuals must be helped to 'cope' with their disabilities and the resulting problems.

Psychological approaches to adjustment to disability

Throughout history scientists and lay people have attempted to link disability and deformity with its effects on the character and personality of the individual (Barker, 1948, Shearer, 1981). These ideas achieved respectability and a scientific home when psychologists, such as Wright (1983), became interested in physical disability. In an early paper, on the social psychology of physical disability, Barker (1948) outlined what was known about the effects of disability on the individual, these included: physically disabled people more frequently exhibit behaviour which is commonly termed maladjusted; the kinds of maladjusted behaviour exhibited by physically disabled people are not peculiar to them, they are similar to those shown by non-disabled people; there is no evidence of a relationship between kind of physical disability and specific types of behavioural maladjustment; people with a long history of physical disability are more likely to exhibit behaviour maladjustment than those with a short history of disability; severely disabled people appear to

have more frequent and more severe adjustment problems than people with milder handicaps.

Barker (1948:32) also compared the problems of disabled people with those of other 'racial and religious minority members' in terms of their 'underprivileged social position' but highlighted one crucial difference. The disabled person, he argued, also had to cope with the fact 'that in some respects he *[sic]* is an inferior person'. This was something other minority groups did not have to cope with. This inferiority was also cited as a justification for the economic oppression and 'underprivileged status' of disabled people:

> one cannot expect industry whose function is production for profit to assume such a present and potential liability [of disabled workers who are inflexible and limited in their work options or are a fire hazard to other employees because of their mobility problems] if other workers who do not present this liability are available. (Barker, 1948: 35)

The major concern, however, was that the disabled person be helped to adjust to her/his situation.

> The problem of getting a disabled person to accept his *[sic]* disabilities and live within his limitations is by no means an easy one ... The ultimate adjustment must involve changes in the value systems of the physically disabled person. (Barker, 1948: 38)

Whilst Wright (1960), who worked with Barker, subsequently refuted the ideas that disabled people were more likely to be maladjusted or to have difficulties with adjustment, the central theme of psychological theories has

been the ways in which disabled people adjust to their disability, their differentness and their inferiority. These theories thus reinforce and justify the oppression of disabled people.

The assumption that many of the psychological theories are based on is that because physical disability involves loss, particularly loss of function, then the process that the disabled person goes through is the same as that experienced by someone mourning the loss of a loved one, the process of bereavement (Parkes, 1975, Oliver, 1983). The bereavement process consists of a number of stages variously proposed to include: disbelief and shock; disorganisation; denial; depression; guilt; anxiety; aggression; and, developing awareness; resolution (Gross, 1992). When applied to the process of adjustment to disability this process becomes (Ibbotson, 1975, Kerr, 1977, Vash, 1981): shock; denial or expectation of recovery; anger/ mourning/depression; rationalisation or acceptance of disability; and finally, adjustment, or as Vash (181: 129) calls it 'embracing the experience'. For Ibbotson (1975) and Kerr (1977), disability is a depressing experience. For Vash, 1981: 129),

> disability is a growth experience which has few parallels in life, an opportunity that can be wasted or exploited. (Vash 1981, p129)

This sentiment echoes that of Malikin and Rusalem (1969) (discussed under the perception of the disabled person as a developing person) and can be seen to underpin the notions of rehabilitation as helping the disabled person to achieve full potential and self-actualisation. This focus on the individual as

the key to her/his own independence and the goal of rehabilitation being to be 'normal', or even super-normal, can also be seen as disempowering and oppressing disabled people.

Albrecht (1976) describes all these stage and process theories as developmental models and argues that they are all based on a number of (possibly erroneous) assumptions:

a) an individual must move sequentially through all of these stages to become fully socialised;

b) there is but one path through the stages;

c) an individual can be placed clearly in one stage by operational criteria;

d) there is an acceptable time frame for each stage and the entire process;

e) movement through the system is one-way.

There are a number of criticisms which can be levelled against these individualistic, developmental theories. The implicit assumptions behind all the theories is that this is *the* path to adjustment and, therefore, an individual who is not depressed must be in denial and is not working through the process. Similarly, if someone is angry, that is seen as a perfectly natural part of the process and so the process of adjustment is used to explain any behaviour. However, both of these points highlight a major flaw in these theories. The assumption is that everything is linked to the process of adjustment to loss of function, whilst ignoring anything else that might be

going on at the same time. Thus, shock is assumed to be the result of the spinal injury rather than due to the disorientation and lack of sensory stimulation that might be associated with admission to a spinal-injuries unit. Depression is assumed to be the result of functional limitations rather than fear of loosing a job and financial worries. Problems with a relationship are attributed to the stress of the injury or disability rather than acknowledged as an ongoing problem. Thus any social or environmental problems are ignored and oppression and disempowerment reinforced.

The process of adjustment can also become the excuse or explanation for any other (probably 'unacceptable' or 'inappropriate') behaviour. A patient who is not co-operating with her/his rehabilitation programme is deemed to be in denial or not adapting to her/his disability, rather than assuming that there is a mis-match between the patient's and the therapist's treatment goals. The effects of this mis-match of goals, which is a central theme of this research, will be discussed later.

The majority of these theories, where they are based on any empirical work, are drawn from studies of people with congenital disabilities, such as cerebral palsy (e.g. Kerr, 1977) or relatively static, traumatic disabilities, such as spinal-cord injuries, rather than on people with ongoing, fluctuating and progressive disabilities. Where there has been research into the process of adjustment, the research has supported the ideas of the stage theories because the underpinning assumptions of the research have been that adjustment is a problematic and painful process and, therefore, any studies

or interventions become self-fulfilling. Disability is always seen as the problem and the consequences are inevitable and negative.

The assumption behind all of these theories and explanations is not only that adjustment is a process which must take place, but also that there is some notional 'good' adjustment. It is this good adjustment which rehabilitation seeks to achieve. However, these notions of adjustment are ideas imposed upon disabled people by non-disabled professionals based on their assumptions of what disability is like. It is not supported by experiential or empirical accounts of the experiences of disabled people (Sutherland, 1981, Oliver, 1990). One of the areas this research aims to explore is how OT students conceptualise the experience of disability.

Sociological approaches to dealing with disability

Whilst the psychologists focus on how the individual deals with the personal impact of disability in terms of her/his self perception, the sociologists tend to focus on how the disabled person deals with the way society views her/him. As Goffman (1968) put it, the focus is on the 'management of a spoiled identity', or of their 'deviant status' (Freidson, 1970) and on attempts to be 'normal' (Goffman, 1968, Albrecht, 1992, Sutherland, 1981). The theoretical roots of disability as deviance are in symbolic interactionism and structural-functionalism, drawing on the work of Goffman (1968) and Talcott Parsons (1951) respectively.

Parsons' main concern was with the maintenance of the social system and the stability of society. For society to function adequately each member of that society must fulfil her/his social role. Illness, and Parsons included disabling conditions under the heading of illness, acts as a threat to the stability of society because people who are sick do not function adequately within their social roles. Medicine acts as a form of social control by defining who can and cannot legitimately take on the sick role. Whilst this model might work for illnesses which are acute and short-term, conditions which are long-term, permanent or fluctuating, in other words most disabling conditions, do not fit within the sick role concept (Kassenbaum and Baumann, 1965, Sutherland, 1981). People with MS or RA (rheumatoid arthritis) cannot 'get well', the condition will never go away and, whilst they may be in long-term remission, they may never return to their pre-morbid level of function or role fulfilment. Someone who is paralysed as the result of a spinal injury may be extremely fit and not perceive her/himself as sick and will, therefore, see no need to relinquish normal social role obligations. Kassebaum and Baumann (1965) were amongst the first to highlight the shortcomings of the sick role ideal type for explaining the role and status of the chronically ill and disabled. The 'disabled role' was first outlined by Sutherland (1981). He argued that whilst disabled people were expected to accept their limitations, they were also expected to be as independent and normal as possible, with the agents of social control (e.g. health care and rehabilitation professionals) helping them to normalise as much as possible. Normalisation is often perceived as being as physically independent as possible (Sutherland, 1981, Shearer, 1981, French, 1994) which can lead to a mis-match between the goals of the

therapist (independence at all costs) and the goals of the client (quality of life) (Brisenden, 1986). These issues will be explored in more detail later in this chapter and within the data for this study.

The symbolic interactionist perspective on disability has focused mainly on how disabled people deal with the physical, functional and social effects of their disability. Locker (1983, 1989), based on his detailed study of disabled people in one London borough, proposed three different sets of strategies for dealing with the different effects of disability:

coping with the disorder; dealing with pain, lack of energy;

coping with the problems of daily life;

coping with the social consequences.

It is with the latter strategy that interactionists have mainly been concerned. Although, as Bury (1982) has been quick to point out, the focus of the interactionist perspective has been on fieldwork and the experiences of disabled people to the detriment of explicit theorising. Whilst the psychologists concentrated their research mainly with disabled people with relatively static disabling conditions, the sociologists have tended to focus their research on disabled people with fluctuating, chronic disabling conditions such as RA (Locker, 1983, Weiner, 1975), MS (Robinson, 1988) or Parkinsons' disease (Pinder, 1988). The assumptions implicit in both the empirical studies and the theoretical discussions are that the problems of the disabled person are not only inevitable, but also that disability is a personal tragedy and it is, therefore, a problem which must be dealt with by the stigma bearer or disabled person. As Locker (1983: 28) said, 'they must learn to be

disabled people at the same time as learning how to limit their disability'. The interactionist view of the inevitability of the problems of the disabled person also means that whilst interactionist research describes the experience of disabled people, it makes no attempt to explain or analyse this experience, thus reinforcing the 'learning to live with disability' approach and reproducing and validating the oppression of disabled people.

Anspach (1979) began to redress the balance by exploring strategies of identity management which begin to see the disabled person as an active participant in the process of defining her/his own disabled identity. Anspach proposes two dimensions of self-concept and whether societal values are accepted or rejected. The combination of these dimensions gives 'a typology of four modal responses to stigma' (Anspach, 1979: 769). These are normalisation, disassociation, retreatism and political activism. Normalisation involves accepting societal values, which label the disabled person as 'not quite normal' within a positive self-concept. So the individual strives to be normal and

> makes a concerted effort to minimize, rationalize, explain away, and downplay the stigma attached to his/her differentness (Anspach, 1979: 769).

Disassociation and retreatism both lead to withdrawal from contact with the 'normal' world, disassociation because of acceptance of societal values and negative self-concept, and retreatism because of rejection of societal values and a negative self-concept.

Where Anspach moves away from the passive personal tragedy model is in the final modality of political activism. Political activism is based on a positive self-concept but a rejection of societal values.

> What I *am* rejecting is society's tendency to set up rigid standards of what is right and proper and to force the individual into a mould ... For a disabled person with a fair intelligence or other gifts, perhaps the greatest temptation is to use them just to escape from his *[sic]* disabledness, to buy a place in the sun, a share in the illusory normal world where all is light and pleasure and happiness. Naturally we want to get away from and forget the sickness, depression, pain, loneliness, and poverty of which we probably see more than our share. But if we deny our special relation to the dark in this way, we shall have ceased to recognise the most important asset of disabled people in our society - the uncomfortable subversive position from which we act as a living reproach to any scale of values that puts attributes or possessions before the person. (Hunt, 1966: 151)

Although Anspach (1979) introduces the notion of the possibility of rejecting societal values, and celebrating differentness, she does not really address the key issue that underlies the political action of disabled people. Disability is not a personal tragedy. Personal tragedy theory accounts of adjustment provide an inadequate account of the experience of disability. A disabled person might have impairments, but the limitation of her/his function is due more to societal barriers than her/his own physical limitations. Disability is not a personal tragedy; it is a form of oppression.

Disability as oppression

The social model has its theoretical roots in conflict theory, where disabled people are seen as a minority group (Albrecht, 1992) in conflict with, and oppressed by, the traditional power-holders within society. Albrecht (1992: 78) sees these power-holders as the 'medical, rehabilitation and government establishment'. The social model of disability, and the perception that disability has its roots in society and the way society views and treats disabled people, draws on three strands of ideas. Shearer (1981: 10), possibly one of the first writer to explore the social aspects of disability, saw the problem and the focus for change as the willingness of society

> to adjust its patterns and expectations to include its members who have disabilities, and to remove the handicaps that are now imposed on their inevitable limitations.

Albrecht (1992: 71) talks of disabled people as a 'minority group' who are attempting 'to regain control over their lives and conditions' and reinforces that within this context

> the problems of persons with disabilities result from living in a disabling environment and not as the result of personal defects or deficiencies (Albrecht, 1992: 79).

The third strand of ideas focuses on the notion that disability is a form of social oppression (Oliver, 1983, Finkelstein, 1980). It is on this strand that we will focus for, as Abberley (1995: 221) argues, OTs 'perpetuate the notion that disability is an individual problem which professional intervention can provide the solution' and thus, OTs are 'key mechanisms through which this oppression is produced and reproduced' (Abberley, 1995: 231).

As Albrecht (1992) and Oliver (1990) have pointed out, the process of naming and defining is an important part of the 'politics of minority groups' (Oliver, 1990: 3) and is part of the process of 'owning', taking over and challenging one's status (Zola, 1993). Thus many disabled people argue to be called *disabled* people, rather than *people with disabilities*, as they want to emphasise their status and place within society as disabled people and to see disability as, what Corbett (1994: 343) calls, 'a proud label'.

Disabled people have taken issue with the WHO definition of impairment, disability and handicap (French, 1992b). The Union of Physically Impaired Against Segregation (UPIAS) redefined impairment as

> lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body (UPIAS, 1976: 3-4, cited in Oliver, 1990: 24)

and thus something of little concern to the social model of disability. Although, as we shall see, issues of impairment (e.g. pain, fatigue or limitation of movement) may still create major problems for the impaired individual. UPIAS redefined disability as

> the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them in the mainstream of social activities. Physical disability is therefore a particular form of social oppression. (UPIAS, 1976: 3-4, cited in Oliver, 1990: 24)

This definition has been refined, into a more usable form by Finkelstein and French (1993: 28), as

disability is the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of the community on an equal level with others due to physical and social barriers.

Oliver (1983) highlights the differences in Shearer's (1981) and UPIAS' (1976) view of the social model. For Shearer the onus is on society, and non-disabled people, to remove the disabling barriers; in other words something that may be done by working to change attitudes and remove physical barriers. For disability activists, the removal of disability barriers is something to be fought for and taken. This highlights the different perspectives of working *for* disabled people or working *with* disabled people to alleviate or remove disabling barriers. The focus of this research has been to explore just how far OT students think they should work *for* or *with* their disabled clients/patients.

Abberley (1987), the first sociologist to attempt to formulate a social theory of disability as oppression, argues that there is ample experiential and empirical evidence that disabled people are, indeed, kept in subservience or 'in an inferior position to other members of society because they are disabled people' (Abberley, 1987: 7). They also suffer injustice and disadvantage because of their disabled status. This position is due 'to an ideology or group of ideologies which justify and perpetuate this situation' (Abberley, 1987: 7). These ideologies are power, patriarchy, capitalism and medicine. Oliver (1990) identifies capitalism, with its emphasis on individualism as the

ideological underpinning of the social construction of disability. Particularly, he highlights able-bodiedism and the focus on 'normality' as core ideologies. The role of medicine and the power of the professional to define someone as disabled and to allocate or withhold services and resources, has already been discussed, and is also an important factor in the oppression of disabled people. Abberley (1987: 17) concludes that a theory of disability as oppression would

> 1) recognise and emphasise the social origins of impairment;
>
> 2) recognise and oppose the social, financial, environmental and psychological disadvantages inflicted on impaired people;
>
> 3) see both 1) and 2) as historical products, not as the results of nature, human or otherwise;
>
> 4) assert the value of disabled modes of living, at the same time as condemning the social production of impairment;
>
> 5) inevitably have a political perspective, in that it involves the defence and transformation, both material and ideological, of state health and welfare provision as an essential condition of transforming the lives of the vast majority of disabled people.

However, the emphasis on the social construction of disability has served to minimise the effects of *impairment* on the disabled person (e.g. fatigue, pain, increased muscle tone), which may be one of the main flaws of the social model (Crow, 1995), and will be discussed further when considering feminist perspectives. It may be that the key role for the OT in some settings is to deal with the problems of impairment rather than the problems of disability.

Oppressive research

Oliver (1990), French (1992b), Finkelstein (1980) and Scullion (1995) argue that the research that has been carried out into the lives and experiences of disabled people is oppressive. It is oppressive both in its methods and its consequences. It is also oppressive because, for the most part, it has been based on the individualistic, personal tragedy model of disability. The research methods are oppressive because, for the most part, the researcher is not disabled, whilst the disabled person is a passive respondent. Disabled people are rarely co-researchers or collaborators in the research design or process. The process of research reinforces, for the disabled respondents

> the idea that the problems they experience in everyday living are a direct result of their own personal inadequacies or functional limitation. (Oliver, 1990: 8)

The outcomes of the research fail to improve the quality of life of disabled people and may only serve to further the academic careers of the researchers (Oliver, 1990, 1996a).

Oliver (1990) highlights the 1986 OPCS survey of disability in Britain as a particular example of oppressive research. The research was conducted through face-to-face structured interviews, and the questions asked included:

> can you tell me what is wrong with you?
>
> what complaint causes your difficulty in holding, gripping or turning things?
>
> does your health problem/disability make it difficult for you to travel by bus? (cited in Oliver, 1990: 7),

all of which reinforce the personal tragedy model of disability. Oliver translated these questions so that they had a social model focus:

> can you tell me what is wrong with society?
>
> what defects in the design of everyday equipment like jars, bottles and tins causes you difficulty in holding, gripping or turning them?
>
> do poorly-designed buses make it difficult for someone with your health problem/disability to use them? (Oliver, 1990: 8).

These questions also highlight the role of the OT in reinforcing the personal tragedy model and reproducing the oppression of disabled people. OTs often focus their interventions on the problems of everyday living, such as opening jars or travelling by public transport, experienced by disabled people. Few OTs, however, have attempted to help disabled people to redesign the jars or buses. They usually provide a piece of equipment that might help with jar opening or attempt to find alternative means of transport.

Just how far OT students are able and prepared to go in understanding, accepting and working within the social model of disability is the central issue being explored in this research.

Feminist perspectives on disability

Perhaps the greatest addition to the understanding of disability and the experiences of disabled people that has come from feminist writers is the fact that there are gender differences in the experiences of disabled people. The focus of the, predominantly white male and spinal-cod injured, disability theorists has tended to ignore differences, not only of gender, but also of

class, age, ethnicity and sexual identity. As Fine and Asch (1988: 3) remark, researchers have

> focused on disability as a unitary concept and have taken it to be not merely a 'master' status but apparently the exclusive status of disabled people.

In their desire to focus on the needs of 'disabled' people as a group, the social model theorists have ignored other issues. The dominant culture of disability theorists and activists has been white and male with a static disability. This is, perhaps, the biggest failing of the social model. There has been a tendency to focus on the similarity of 'disability' to the exclusion of the vast range of impairments and conditions that make up disability (e.g. deafness, blindness, paraplegia, hemiplegia following stroke, multiple sclerosis), let alone the differences in experience resulting from gender, race, class, age and sexual identity.

In an attempt to see the picture as a whole, this research has also fallen into the trap of focusing exclusively on disability. However, it was done for the best of intentions, and it could be argued that the oppressive reactions of health care workers are common to all physically disabled people.

Whilst a number of authors (e.g. Fine & Asch, 1988, Deegan & Brooks, 1985, Morris, 1989) have written about the experiences of disabled women, it is Wendell (1996) who has attempted a synthesis of feminist theory and disability experience to produce a feminist reflection on disability. Prior to this, feminist theory had largely ignored disability issues, or, as Morris (1996)

points out, had focussed on the 'double disadvantage' of being female *and* disabled. Meekosha (1998: 166) is highly critical of feminist 'hostil[ity] to the inclusion of disability within its frame of reference', arguing that

> enabling the diversity and fluidity of gendered and embodied lives to be voiced will render feminism richer, more coherent and more relevant (Meekosha, 1998: 166).

It is only when disabled women, such as Morris (1996), Crow (1995, 1996) and Wendell (1996) began writing and exploring these issues, that the disabled woman's voice was truly heard within feminist theory.

Using the feminist concept of 'the Other' (those who are not part of the taken-for-granted everyday world of the dominant culture – white, male, heterosexual, healthy and young), Wendell (1996) explores the symbolic meaning of disability. She argues that disability should be seen, not as stigma or not normal, but as 'difference' (1996: 66). Difference is value-neutral and

> it is therefore possible and necessary to ask whether a particular kind of difference is as good as or better than 'normality' (Wendell, 1996: 66).

However, although difference is value-neutral, it is something that is noticed. Disabled people are different and, therefore, it is their disability that becomes the focus rather than their similarities to non-disabled people. Differences are to be valued and can provide insights, which are not available to the non-disabled.

Sacks (1996), although much criticised by disability researchers (e.g. Shakespeare 1996), demonstrates how differentness must be seen in the context of its meaning for the individual and argues that being different should not be seen as a disadvantage. Seeing differences as valuable leads to the possibility of acknowledging that disabled people, by virtue of their differentness, may have experiences and knowledge which are not open to non-disabled people. Rather than the non-disabled teaching disabled people how to 'cope' with their disability as part of their rehabilitation to be normal, disabled people could teach the non-disabled world ways of dealing with pain, frustration and uncertainty. These insights could be used to explore and understand both the subjective and the objective reality of impairment.

These insights highlight two major issues for the study of professional attitudes. Do we, as therapists, focus on the similarities or the differences, and how much do we value the knowledge of our disabled clients?

By proposing that the non-disabled world can learn from the experiences of disabled people, Wendell (1996), from a feminist perspective, highlights an issue for both the Social and Independent Living models of disability. The Independent Living model focuses on the shared experiences of disabled people which are used to achieve change, and the social model highlights and celebrates 'difference'. However, neither of these models acknowledges that the sharing of similarities and the ability of the non-disabled to learn from the experiences of disabled people may bring about social action and change.

The absence of the individual voice within the social model is also highlighted by Shakespeare, Gillespie-Sells and Davies (1996). They argue that disabled feminists, such as Morris (1996), and Deegan and Brooks (1985), are wrong to talk about a 'false generic' within disability studies. The false generic proposes that when 'disabled people' are spoken of it, in fact, refers to 'disabled men'. Shakespeare et al argue that disabled men's experiences have, in fact, been under-represented and explored. Ignoring the experiences of disabled individuals is both disempowering and oppressive.

Disabled people, because of their impairments and limitations, highlight the frailty and vulnerability of the body and of the reality of the non-disabled world. They emphasise the myth of our ability to control our bodies. Because of this, disabled people are stigmatised. Anything that non-disabled people can learn from the experiences of disabled people about dealing with frailty and vulnerability is lost.

> The idealization of the body, the myth of control, and the marginalization of people with illnesses and disabilities mean that much knowledge about how to live with limited and suffering bodies is not transmitted in cultures where these influences are powerful (Wendell, 1996: 109).

If, however, the non-disabled could learn from the experiences of disabled people and could begin to share in the disabled reality, then non-disabled people might work to create an accessible environment and reduce the oppression of disabled people.

Here, again, the feminist perspective highlights the potential exclusivity of the social model of disability. Within the social model the major emphasis is on disabled people creating radical change. Wendell's (1996) perspective allows for a more shared approach to social action and change. Non-disabled people can cease to be the oppressor and can share with disabled people in changing social and cultural constructions of disability. This feminist perspective on the social model can help disability theorists to begin to acknowledge that it might be possible for health professionals, such as OTs, to work *with* disabled people in creating an accessible environment.

Meekosha (1998) has argued for an integration of feminist theorising of the body with disability theory. This will help disability theory move beyond the 'rigid dualism of either a socially constructed disability or a disability grounded in biology' (Meekosha, 1998: 175). By integrating the subjective discourse of disability, through the lived experience of disabled people, issues of impairment experience as well as issues of gender, race, class, age and sexual identity can become part of the discussions of the oppression of disabled people. Crow (1995, 1996) and French (1993) have also highlighted the fact that the social model ignores the subjective experience of impairment.

The sociology of the body and particularly Seymour's (1998: 26) study of the 'processes involved in remaking the body after severe change or loss' provides a way of highlighting the potential of the social model to oppress and disempower disabled people. The focus on the body may, at first, seem

to be oppressive, as it appears to be highlighting the personal tragedy of disability for the individual. However, by highlighting the potential to remake the body, this perspective may, in fact, be more empowering than the social model.

Seymour (1998), in her study of men and women who have experienced spinal cord damage, acknowledges that disability is a catastrophe and a crisis. However this is not a completely negative experience, as it offers the individual the opportunity to break the mould of their previous socially constructed body and transform and reconstruct their body in a way better suited to themselves and their image as a disabled person. This crisis can be seen to give the individual a second chance. As a Chinese proverb states: crisis = danger + opportunity. Seymour (1998) argues that viewing disability through the perspective of the sociology of the body, it is possible to see disability as danger + opportunity. The disabled individual, however, may not be able to re-create her/his body, but may remain with her/his previous stereotypes or adopt society's model of the disabled identity (which has been explored in previous sections of this chapter). This notion of remaking the body has implications for rehabilitation which will be explored further later in this chapter.

Disability and empowerment

Empowerment can be defined as

> to give power to, or make able (Allen, 1990: 384);

> a process of becoming increasingly more in control of oneself and one's life, and thus increasingly more independent (Fenton & Hughes, 1989: 11).

These are the definitions which underpin this study. Although Servian (1996) argues that defining empowerment is not a straightforward process, it is inevitably linked with definitions of power. Empowerment also means different things to different people as can be seen from the following definitions of empowerment identified by Servian (1996: 5-7):

> Empowerment as control of industry;
>
> Empowerment as changing workplace technology;
>
> Empowerment as access to democratic processes;
>
> Empowerment as taking leadership;
>
> Empowerment as changing the value base of an institution;
>
> Empowerment as meeting specific needs or rationing resources;
>
> Empowerment as permission;
>
> Empowerment as freeing from government;
>
> Empowerment as advocacy;
>
> Empowerment as spiritual enlightenment.

Finding a common thread amongst all of these definitions is difficult. The common theme would appear to be linked to giving, or achieving, power for particular groups or individuals. However, power is often given to those who are already powerful and the needs of the least powerful are often ignored.

Servian (1996) used predominantly psychological perspectives to explore perceptions of power and empowerment in a service for people with learning

disabilities. He argued that Tajfel's (1981) theory of 'social identity' could be used to explain and analyse social and political action and group empowerment, whilst Seligman's (1975) theory of 'learned helplessness' could be used to explore and analyse individual empowerment and disempowerment. Whilst Servian found that these theories could be useful in exploring individual perceptions of power and empowerment, neither theory allows an exploration of the underlying oppression of people with learning disabilities. Seligman's theory of 'learned helplessness' may be useful in exploring OT students' perceptions of disabled clients' responses to empowerment.

Much of what Servian found can be summed up in the principles of empowerment outlined by Barnes and Walker (1998) for the empowerment of the users of health and social care services. By applying these principles to any action may be a way of ensuring that power is not retained by the powerful. Barnes and Walker's principles of empowerment are:

> Empowerment should enable personal development as well as increasing influence over services;
>
> Empowerment should aim to increase people's abilities to take control of their lives as a whole, not just increase their influence over services;
>
> Empowerment of one person should not result in the exploitation of others;
>
> Empowerment should not be viewed as a zero sum: a partnership model should provide benefits to both parties;
>
> Empowerment must be reinforced at all levels within service systems;

Empowerment of those who use services does not remove the responsibility of those who provide them;

Empowerment is not an alternative to adequate resourcing of services;

Empowerment should be a collective as well as an individual process.

For disabled people, empowerment has been both personal and political. Control is the central theme (Charlton, 1998). Personal empowerment means a sense of control and a sense of competence. A sense of competence can counter the apathy and learned helplessness identified by Servian (1996). Personal empowerment is exemplified by the Independent Living Movement. Political empowerment can be seen in the work of disability activists and the disability movement.

The Independent Living Movement began in America where disabled students grouped together to pool their resources and take control of their own lives. The principles behind Independent Living are those of the social model of disability, translated into an intervention paradigm (DeJong, 1979, 1983. The principles of the Independent Living Paradigm are compared to the rehabilitation model/ paradigm in Figure 2:1. (The rehabilitation paradigm will be discussed in the next section).

Figure 2:1: Comparison of the rehabilitation and Independent Living paradigms

	Rehabilitation paradigm	Independent Living paradigm
definition of problem	physical impairment, lack of vocational skill, psychological maladjustment, lack of motivation and co-operation	dependence on professionals and relatives etc., inadequate support services, architectural barriers, and economic barriers
locus of problem	in the individual	in the environment, in the rehabilitation process
solution to problem	professional intervention by physician or therapist	peer counselling, advocacy, self-help, consumer control, removal of barriers and disincentives
social role	patient/client	consumer
who controls?	professional	consumer
desired outcome	maximum ADL*, gainful employment, psychological adjustment, improved motivation, completed treatment	self-direction, least restrictive environment, productivity (social and economic)

source: DeJong (1979: 443, 1983: 23)

**activities of daily living (ADL)*

Although Williams (1983) has argued that the Independent Living Movement is of value only to a young, middle-class, articulate disability elite, this is not the case. Independent Living is rooted in the radical humanist perspective and has given disabled people the opportunity both to challenge prevailing

stereotypes of disability and to establish alternative types of service provision which are under the control of disabled people themselves rather than health and social care professionals. The Independent Living Movement continues to provide a focus for personal empowerment through the Centres for Independent and Integrated Living (CILs) and Disability Information and Advice Lines (DIALs) which are run by disabled people for disabled people throughout the UK (Oliver & Barnes, 1998). The next chapter will discuss how, and whether, health professionals, in particular OTs, work within the Independent Living philosophy to empower or disempower disabled people.

Political empowerment for disabled people has come though the politicisation of disability and the work of organisations run by and for disabled people, such as the Union of the Physically Impaired Against Segregation (UPIAS), the British Council of Organisations of Disabled People (BCODP), the Disablement Income Group (DIG) and Disabled People's International (DPI) (Campbell &Oliver, 1996, Barnes, 1998, Charlton, 1998). Much of the impetus for this political empowerment has come from the social model of disability (Hasler, 1993, Campbell & Oliver, 1996, Barnes, 1998).

Disability activists can often appear to disempower the professionals leading to conflict and disempowering actions by the professionals (Abberley, 1995). This research will explore OT students' reactions to these issues of balancing empowerment with disempowerment.

Disability and rehabilitation

Whilst chapter 3 will explore the particular role of occupational therapy within the rehabilitation of disabled people, this section will explore the impact of rehabilitation upon the social construction of disability.

Drawing on the Parsonian concept of the 'sick role' *(discussed previously),* Safilios-Rothschild (1970) articulated the 'rehabilitation role'. This has also been articulated by DeJong (1979, 1983) as the rehabilitation paradigm *(see above)* and by Albrecht (1992: 85-86) as the rehabilitation model:

goals:	care and normalisation of disability;
values:	patient actively participates and is informed; physician advises, rehab. professional has the knowledge;
definition/ diagnosis:	the doctor makes the diagnosis, but rehab. experts advise and control the treatment;
aetiology:	client is permanently impaired or disabled;
treatment:	few cures, emphasis on rehab. to highest level of function possible;
prognosis:	improvement and stabilisation but not cure;
function of institution:	institutions provide the place for rehab.;
rights and duties of client:	must try to normalise conditions and behaviour; takes an active role, protection from exploitation.

The ideology common to all of these views of rehabilitation is 'normality' (Oliver, 1990, 1996b, Albrecht, 1992). Within rehabilitation, the disabled individual must assume as many 'normal' functions as possible, as quickly as possible. The client must co-operate with the rehabilitation professionals and must be motivated to return to normality and especially the normality of work (Safilios-Rothschild, 1970). It is the disabled person's responsibility to return to 'normal', however, s/he is dependent upon the rehabilitation professionals

to establish treatment/intervention goals, to design the rehabilitation programme and to monitor the successful outcome of rehabilitation. Part of the rehabilitation process is the successful transition though the stages of psychological adjustment to the 'tragedy' of disability *(these stages were discussed above).* Implicit within this view is the notion that, whilst the disabled person must attempt to return to 'normality' they will never be completely normal as they will always have to cope with the tragedy of disability. This view is well illustrated in the, somewhat dated but still highly pertinent, seven stages of rehabilitation identified by Moos and Tsu (1977):

minimising;

seeking knowledge;

needing reassurance;

learning skills to cope with limitations;

setting manageable goals;

rehearsing alternative lifestyles;

finding meaning to a reduced life.

Rehabilitation, Seymour (1998) and Barnes (1998) argue, is a key factor in the social construction of disability. Rehabilitation is the process by which disabled people learn to be 'disabled' within society. This process can be inherently oppressive, especially with its focus and ideology of normality. A 'normality' to which disabled people can never aspire. Rehabilitation can create and reinforce notions of dependency, failure and learned helplessness.

Normality is usually translated into the goal of independence. However, the notion of independence is often the root cause of conflict between the professional and the disabled client. For the OT, independence is often seen in terms of 'independence in ADL', in other words, being able to cope with self care activities, like getting dressed and going to the toilet, and domestic activities, like cooking and ironing. For the disabled person independence is often seen as more to do with quality of life, choice and the ability to make decisions or be in control of one's life (Wendell, 1996, French, 1994, Oliver, 1990, Sutherland, 1981, Brisenden, 1989). Definitions of independence will be explored in more detail in chapter 3.

Rehabilitation, for Seymour (1998: 107) is a 'process of re-embodiment'. It is a time for re-making the self-identity in the light of the disabled person's new body state. This process can be positive

> many people have used the crisis to actively engage with and explore embodiment and in so doing have questioned and challenged conventional categories related to masculinity and femininity in our society. Embodied rehabilitation reconstitutes embodiment (Seymour, 1998: 43).

However, this may be in spite of, and not because of, the rehabilitation process. According to Seymour (1998: 107)

> sport and the ideology of athleticism are critical components of the formal rehabilitation process.

Rehabilitation is, essentially, a masculine process.

Oliver (1996a) uses walking, non-walking and nearly-walking to explore the oppressive nature and ideology of rehabilitation. Walking, in Oliver's analysis, is synonymous with independence in any functional activity, e.g. dressing, bathing.

> The aim of rehabilitation is to encourage walking and nearly-walking, and to control though therapeutic interventions, non-walkers and nearly-walkers both individually and as a group (Oliver, 1996a: 106).

Power and control are central to rehabilitation. The connection between this power, control and the social construction of disability is encapsulated in Oliver's reworking of Foucault:

> an essential component of the rehabilitation enterprise is the key role it plays in the systematic creation, classification and control of anomalies in the social body (Oliver, 1996a: 106).

A central flaw of rehabilitation, according to Oliver (1996a,b), is that the concepts of 'normality' and psychological adjustment are accepted uncritically by rehabilitation professionals. The nature of 'normality' is never analysed. The stages of psychological adjustment have been analysed, but from the perspective of non-disabled psychologists and sociologists working on the assumption that disability is a personal tragedy and a negative experience which must be lived through and come to terms with.

> The reality [and] the ideology of ... many rehabilitation practices, is that they are oppressive to disabled people and an abuse of their human rights (Oliver, 1996a: 107).

The ideology of normality and the oppressive nature of rehabilitation can be seen particularly in the concept of 'normalisation'. Whilst the focus of normalisation has been people with learning disabilities, a brief exploration is relevant here to aid our understanding of the role of rehabilitation in the social construction of disability and the oppression of disabled people. Normalisation spans the functionalist and interactionist paradigms (Fulcher, 1996). It acknowledges, unquestioningly, the power of the professional and is also concerned with the inevitability of deviance, stigma and negative attitudes.

Normalisation was the philosophy which underpinned services for people with learning disabilities, especially the move to community care, in the 1970s and 1980s. Normalisation principles (Wolfensberger & Tullman, 1989), later refined to 'social role valorisation' (Wolfensberger, 1995), proposed that people with learning disabilities (like all disabled people) are devalued by society and have stigmatised identities. These devalued and stigmatised identities are reinforced by poor quality services, thus creating a vicious cycle. This cycle can be broken by creating high quality care services which will create high quality lifestyles for people with learning disabilities, enabling them to mix with people who have socially valued identities.

The concept of socially (or culturally) valued identities is the major flaw in normalisation and one of the keys to its role in the oppression of disabled people. As we have already seen, the identities which society values are those of the dominant cultural group (i.e. white, male, able-bodied, healthy,

middle-class). Disabled people, within normalisation, are being asked to conform to these norms in order to be accepted; they are not to be accepted unconditionally, thus reinforcing their devalued status. Because disabled people need to associate with people with high social value, care services should ensure that they are given the skills to do this by including social skills training as part of the rehabilitation package. By focusing on developing relationships with socially valued people, interaction with other disabled people is discouraged. Thus being isolated from important potential sources of friendship and support and also the potential for collective political action further disempowers disabled people.

The other key to understanding normalisation's oppression of disabled people is the role of the professional within normalisation. Because of its basis within the functionalist paradigm, normalisation accepts without question the power relationship between professionals and service users. Rather than seeking to change this relationship, it reinforces it by providing the principles for developing a high quality professional-led service. No attempt is made to explore the social, economic or political context of these services. The professionals decide how the service should be developed and improved. As Chappell (1997: 48) notes

> normalisation may have influenced many professionals, but it has not been adopted as a model of change by disabled people themselves or any organisations which are accountable to disabled people.

Chappell goes on to argue for the inclusion of people with learning disabilities within the social model of disability as a way of furthering the understanding of the oppression of disabled people.

This research will explore whether an understanding of the social model of disability helps OT students develop less oppressive ideas of rehabilitation, and whether these ideas of rehabilitation are drawn more from Independent Living principles than from normalisation principles.

Conclusions

The final tasks of this chapter are to locate the ideas and theories discussed within the framework developed in the Introduction and to look critically at those theories. The central theme of this chapter has been the oppression of disabled people. This oppression takes many forms and has many explanations. Oliver (1990) and Finkelstein (1980) proposed the notion of the social creation of disability. Other explanations propose the notion that disability is a social construction and that the oppressed position of disabled people in society is due to the images non-disabled people have of disabled people. These constructs can be based on notions of 'otherness' (e.g. Wendell, 1996), deviance and stigma (e.g. Goffman, 1968), disability as a medical problem and a personal tragedy. Negative images of disabled people as dependent and in need of care can also be constructed by the rehabilitation process.

Figure 2:2 illustrates where the different forms of oppression relate to Burrell and Morgan's (1979) paradigms and the models of disability. The terms 'empowerment' and 'oppression' have been added to the radical change – regulation dimension. The dimensions of subjectivity and objectivity are retained as disability has both an objective and a subjective reality. The theoretical constructs pertinent to each model have been included. Feminist theory and normalisation have also been included and are seen to span the subjective/objective divide. Feminist theory clearly attempts to address issues of radical change from both a subjective and an objective perspective, whilst normalisation, as has been discussed, is located with the regulation paradigm. The models of disability located at the radical change end of the dimension, the independent living and social models, are primarily concerned with changing and challenging the oppression of disabled people by changing society and empowering disabled people. The models at the regulation end of the dimension, the medical and rehabilitation models, have been identified as maintaining the status quo, i.e. maintaining the oppression of disabled people by keeping power and control in the hands of the professionals. However, the author would like to add a note of caution here. The division between empowering and oppressive models may not be so clear cut. The social model may oppress disabled people and the medical model may empower disabled people. These are the complexities which this research will attempt to explore.

Figure 2:2: Paradigms and theories of disability

radical change: empowerment

radical humanist: independent living	***radical structuralist: social model***
self help – personal empowerment *celebration - a proud label – positive images* *minority group identity* **subjective** *feminist*	*disability as oppression (social creation)* *political activism – collective empowerment* *theory* **objective**
subjective *normal*	*isation* **objective**
personal tragedy - the need for adjustment *disability and stigma* *negative perceptions and images of disability (social construction)*	*administrative definitions* *personal tragedy - the need for treatment* *disability as deviance*
interpretive: rehabilitation	***functionalist: medical***

regulation: oppression

Oppression can be seen as the restrictions, controls and limits placed on disabled people. As we have seen in this chapter, the causes of this oppression can be located in a variety of places. Disabled people are labelled as different, not quite normal and deviant, they, therefore, need treatment and interventions to make them as normal as possible (the medical model). Disabled people have problems which they need help to adjust to, they need to deal with the negative images society holds about disabled

people, and, therefore, they hold about themselves (the rehabilitation model). For both of these models, disabled people need professionals to help them to adjust to their disability. The professional will work with disabled people to help them to adjust to and cope with their disabilities. However, the professional holds the power and controls the choices available to the disabled person. Thus the disabled person is oppressed. These models of disability (the medical and the rehabilitation models) emphasise the personal tragedy and individual nature of disability. They focus on the regulation and control of disabled people.

The other two models of disability, the independent living and the social models of disability take a more radical and, potentially empowering, approach. They emphasise the power and the control disabled people can (and must) take in their own lives and how disabled people can act to challenge their oppression. The social model, particularly, locates the oppression of disabled people within society, either with the political economy and the social organisation of work (Oliver, 1991, 1996a) and/or in the discriminatory attitudes of society in general. The location of oppression within the social organisation of work is important in understanding the role of OT within the oppression of disabled people. Not only are OTs amongst the professionals who work with disabled people, and who can limit their control over their lives, the focus of OT on activity and occupation can also reinforce the oppression of disabled people in terms of their place in the social organisation of work. This theme will be explored in more depth in chapter 3.

Within the independent living model the oppression is located within the social institutions, and in particular the professionals, such as OTs, (and families) who seek to care for and control the lives of disabled people. Whereas the social model addresses society and changes to society, the independent living model tends to address ways of empowering the disabled individual to take a more fulfilling role in society. Within independent living the emphasis is on the professionals working *for* rather then working *with* the disabled person, the disabled person is a consumer of services rather than a patient. Arguably professionals have little or no place within the social model, unless it is to work with disabled people in changing institutionalised disablism.

Whilst there are great benefits for the empowerment of disabled people within both the independent living and social models of disability, there are also weaknesses. As we have seen, these models tends to see 'disabled people' as an homogeneous group, making it difficult to explore diversity of gender, class, age, race and sexual orientation. These models ignore the body and the experience of impairment. In doing this, the independent living and social models may also oppress disabled people. The medical and rehabilitation models focus, almost exclusively, on the physical body and its impairments and ignore the social, economic and political contexts of disability. However, it is all too easy to be drawn into nihilism about these models and to assume that everything about them is oppressive. For some disabled people focusing on the body and its impairments may be empowering rather than oppressive.

This chapter has explored the social construction of disability, with particular emphasis on the oppression of disabled people and the role medicine and rehabilitation plays in that oppression. Themes, which have been discussed in this chapter, include:

definitions of disability;

images and stereotypes of disability;

control and power within the therapeutic relationship;

working *with* or *for* disabled people;

the place of the professional;

form themes to be explored in the series of interviews with the OT student cohort in this study. These themes will be re-explored later in the light of the findings of this research.

Chapter 3

OCCUPATIONAL THERAPY: AN OPPRESSIVE PROFESSION?

Occupational therapy helps people live more productive and enjoyable lives. It's a way of helping individuals to do desired activities and thereby become much more independent. Occupation means any manner in which you spend your time from: *personal care* (getting dressed, cleaning your teeth, shopping, washing); to *productivity* (paid or unpaid work, housework or school); to *leisure* (sports, games, hobbies, social life). (College of Occupational Therapists, 1995: *i*)

This quote comes from a publicity leaflet published by the College of Occupational Therapists (the United Kingdom OT professional body) aimed at explaining occupational therapy to the general public. The title of the leaflet is 'Make the most of every day', but the sub-title is 'How occupational therapy helps make you more independent'. The question that this leaflet raises is what exactly is 'independence' and what exactly is the occupational therapist's role in *making* someone more independent. This chapter will begin by exploring the philosophies and concepts which underpin current occupational therapy practice, it will then explore other notions of independence, from the Independent Living Movement, and similar, perspectives. The chapter will conclude by returning to Burrell and Morgan's (1979) paradigm framework and identify where occupational therapy practice might be located within the different models of disability, independence and practice which can be developed from these paradigms. The goal of this chapter echoes the goal of this research, to explore how empowering or oppressing occupational therapists actually are in their practice.

Defining independence

The practice of occupational therapy is concerned with helping clients to become independent, but before we can explore what the concept of independence means within the context of occupational therapy it is important to explore the general notion of independence. Independence has been defined as

> being unwilling to be under obligation to others (Allen, 1990: 601);
>
> choosing how to live one's life within one's inherent capacities and means and consistent with one's personal values and preferences (Turnbull & Turnbull, cited in Fenton & Hughes, 1989: 18).

These definitions do not appear to sit very comfortably with the image of independence and occupational therapy given above, where independence would appear to be much more concerned with doing things for oneself, such as getting dressed or cooking a meal, rather than with being able to make choices about how one lives one's life.

The question for this chapter and this study is how much power, control and independence occupational therapy students enable their patients and clients to have, and also how sensitive these students are to the complex issues surrounding independence and empowerment.

Independence and occupational therapy

Reed and Sanderson (1992) locate occupational therapy within the study of, what they refer to as, human occupations. They divide human occupations into three broad areas: self-maintenance; productivity; and leisure. When the

activities within these three areas are all performed to a 'normal' standard and the individual has the occupational skills and occupational functions to perform these tasks, then that individual is deemed to have 'achieved a state of adaptation and health' (Reed & Sanderson, 1992: 12). For Reed and Sanderson, the main purpose of occupational therapy intervention

> is to develop and maintain the individual's capacity, throughout the life cycle, to perform with satisfaction to self and others those occupational tasks and roles essential to productive living and the mastery of self and the environment. ... Occupational therapists further assume that .. positive effects occur when a person has achieved a basic level of functioning in the three occupational areas of self-maintenance, productivity and leisure and can balance the needs for each occupational area with a life-style that is acceptable to the individual and community environment (1992: 10-11):

independence within this conceptualisation of occupational therapy can, therefore, be seen in terms of functioning or being able to do things for oneself, and that if the individual is unable to do things for her/himself then 'adaptation and health are compromised' (Reed & Sanderson, 1992: 13).

Although Reed and Sanderson highlight three occupational areas, the area of self-maintenance appears to be the most important and to underpin the other two occupational areas. Thus if the individual cannot function in self-maintenance s/he is unlikely to be able to function in the areas of productivity and leisure:

although each individual has a unique combination of self-maintenance needs, there are common areas, including eating, dressing, toileting, mobility, communicating, and problem-solving. These self-maintenance needs *must* (italics added) be performed. If the individual cannot perform the skills needed to complete these activities, someone else must perform part or all of the self-maintenance activities for the person. The more someone else must assist in self-maintenance activities, the less independence an individual can achieve in managing all occupational functions. In addition, the cost in terms of the resources of time and money are greater for a dependent person than for one who is independent. (Reed & Sanderson, 1992: 13-14)

Lack of ability to perform occupational tasks and fulfil occupational roles has other costs, as well as time and money; health is compromised and lack of functional independence can lead to feelings of helplessness and hopelessness. However, occupational therapy intervention can help by replacing

> feelings of hopelessness and helplessness with the feelings of being able to perform at least some of the daily living tasks independently or with minimal assistance (Reed & Sanderson, 1992: 20).

The focus for independence in Reed and Sanderson's concepts of human occupation, occupational performance and occupational therapy is to be able to do as much for oneself as possible in the areas of self-maintenance, productivity and leisure. If the individual is unable to fulfil these occupational

tasks and roles then s/he is a drain on resources and an unproductive member of society. These concepts can be located within the rehabilitation paradigm, where the individual is facilitated to function as independently and as normally as possible.

The concepts of self-maintenance and the rehabilitation model of practice are often the easiest of the occupational areas and models of practice to grasp, and for this reason the focus of the 1st year occupational therapy modules, for the cohort in this study, tended to be aspects of self-maintenance and the rehabilitation approach to intervention, thus reinforcing the concept of independence as the ability to function rather than wider, 'choice'-based, definitions of independence. One of the tasks for the interviews in this study was to explore with the respondents their concepts of independence and how these might influence their interventions with patients/clients. From this outline of some of the central concepts of occupational therapy it might be assumed that 1st year students, at least, might use functional concepts of independence and a rehabilitation focus for intervention.

Occupational therapy and the medical model

Occupational therapy has traditionally been described as a profession 'supplementary' to medicine (e.g. the Council for the Professions Supplementary to Medicine), although the preferred term now is a profession 'allied' to medicine. Both of these descriptors, however, emphasise the medical roots of the profession and place the practice of occupational therapy firmly within a medical context, if not within the medical model of practice. The

ways the profession defines itself also reflect the medical aspects, as occupational therapy intervention is described as 'treatment':

> the *treatment* (emphasis added) of physical and psychiatric conditions through specific selected activities in order to help people reach their maximum level of functioning all aspects of daily life (World Federation of Occupational Therapists, 1989, cited in Hagedorn, 1992: 71-72);
>
> occupational therapy is the assessment and *treatment* (emphasis added) ... of people ... with physical and mental health problems, through specifically selected and graded activities (Blom-Cooper, 1989: 14).

These definitions locate the practice of occupational therapy firmly within the medical model with its emphasis on assessment/diagnosis and treatment. Linked to, but not identical to, the medical model is the rehabilitation model. This model is also firmly medically oriented but the emphasis is less on 'cure' and more on 'return to normal function' through treatment and adaptation to disability.

Within both the medical and rehabilitation models, the emphasis is on treatment to return the patient to as normal a state of function as possible. The amount of choice or control that the patient has is very limited, with the therapist in charge of the process of treatment throughout. The focus of the medical/rehabilitation models and of the definitions of occupational therapy cited above is on the *dys*function and *dis*ability of the patient not upon her/his abilities, functions and strengths. The patient is placed in a position of dependence and weakness, not only because the therapist controls the

treatment process, but also because the premise that the therapist has is that the patient is someone with limitations and problems that prevent her/him from functioning normally or adequately, and that it is the therapist's job to reduce these limitations and improve functioning.

Christiansen (1991) argues that occupational therapy should more accurately be described as a 'health' discipline rather than a 'medical' discipline. The focus of occupational therapy has always been on the effect of activity/ occupation on health, the development and enhancement of health though occupation and the effect of disease/disability/injury on everyday living. The practice of occupational therapy takes place within a medical context, but not within a medical model.

The history of occupational therapy demonstrates its moves towards and away from the medical model. Occupational therapy began to develop, firstly in the United States of America, as a consequence of the carnage of the First World War, and the problems created (especially in terms of return to employment) following industrial injuries and long term illness such as TB (tuberculosis). The focus of occupational therapy in its founding stages was the use of occupation to treat the whole person, not just the affected limb, and to facilitate a return to health (and employment) through activity (Christiansen, 1991).

Beginning in the 1930s a change took place in occupational therapy with a move away from the holistic framework to a much more reductionist (medical)

framework. The emphasis of treatment moved from function as a whole to the components of function. Activities were still used, but to treat range of movement, muscle strength or disturbed thought processes, using treatment models which reflected this reductionist focus: the biomechanical (or kinesiological) model; the psychoanalytic or interpersonal model; and the sensory integration or neurological model (Kielhofner & Burke, 1977). The person in her/his social context was becoming lost in the emphasis on the minutiae of function. Functional performance had been taken out of its everyday context.

Rogers (1982) emphasises the differences between medicine and occupational therapy. She focuses on how the two disciplines conceptualised 'order' and 'disorder'. She proposes that order is the desired state of affairs, however, order for medicine and occupational therapy is different. In medicine the desired state of affairs is the absence of illness (a somewhat negative view of health), whereas in occupational therapy the desired outcome is competent functioning in the occupational areas of self-care, work and play. Disorder in medicine is disease, but in occupational therapy it is problems with the functions of everyday life or 'performance dysfunction' (Christiansen, 1991: 5). Thus a patient might have a medical disorder but have no problems with daily living, or an individual might have no medical disorder but have problems with everyday living, and so need the skills of an occupational therapist but not a physician. The differences in concepts of order and disorder can also be seen in the ways occupational therapists conceptualise health and illness and the problems this might create for

therapists when discussing their patients with members of the medical profession (Taylor, 1990).

Reed and Sanderson (1992) have analysed the relative merits and values of a range of models of health in relation to the practice of occupational therapy. They argue that all models of health are based on one of two paradigms. These paradigms are 'mechanistic' and 'organismic'. The mechanistic paradigm sees the individual as a machine composed of a series of parts where 'the external environment largely determines the person's decision-making and actions' (Reed & Sanderson, 1992: 38). In complete contrast, the organismic view is of the person as a living, integrated whole who is in control of her/his activities and decisions about life and health.

Reed and Sanderson agree with Rogers (1982) that the medical model is of limited value to occupational therapy. They reinforce the notion of conflict between occupational therapy and medicine highlighted by Rogers (1982) and Taylor (1990) and add other potential areas of conflict for the physician and the therapist; within the medical model control and decision making is the prerogative of the physician, however, with occupational therapy the

> person can and should control the decision-making and take responsibility for individual action to the maximum degree. (Reed & Sanderson, 1992: 40-41)

The second area of conflict is in the focus of assessment which for the physician is dysfunction and for the therapist is skills and abilities as well as dysfunction.

Whilst the medical model can be seen as the most oppressive model of health with its focus on disease, cure and control, all of the models of health presented by Reed and Sanderson are oppressive. The focus of treatment and change in all of the models is the individual; illness or disability is seen as the individual's problem or personal tragedy. None of the models proposed by Reed and Sanderson make any reference to changing society or the societal aspects of health and disability.

Polatajko (1992) reminds the reader that medicine has found the illness model inadequate and limiting. This has led to the development of the 'disablement model' which highlights the consequences of disease in terms of impairment, disability and handicap. Occupational therapy should focus intervention on handicap rather than impairment or disability.

> Given that occupation is defined as activities or tasks which engage a person's resources of time and energy, specifically self-care, productivity and leisure; and that occupational performance is defined in relation to the environment, it follows that handicap is the proper focus of occupational therapy. Handicap, not disability, is defined in terms of the environmental influence on function. (Polatajko, 1992: 195)

However, Polatajko goes on to argue that occupational therapy should practice within an 'enablement model' where the focus is on abilities, skills and competence rather than on the negative consequences of illness and disability.

> Occupational therapy is the discipline concerned with enabling occupational competence guided by an understanding of the individual, the environment and their interaction in determining occupational competence. (1992: 197)

Whilst this acknowledges the broader perspective of 'handicap' and the effects of the environment, the focus still appears to be on the individual rather than on society.

Reed and Sanderson (1992: 51) argue that occupational therapists must 'select ... aspects ... that most closely fit the beliefs and values of occupational therapy'. In our attempt to assess whether occupational therapy is an oppressive profession, the discussion will now focus on those beliefs and values of practice.

Professional values

Yerxa (1983) has outlined the values of occupational therapy and has described them as 'audacious' because of their inherent conflict and inconsistency with those of the medical framework in which so many occupational therapists practice. Yerxa summarised the values of occupational therapy as:

> those of belief in the essential humanity of patients and their right to life satisfaction; concern with health and enhancement of the healthy aspects of the person; fostering patients' self-directedness and ability to take responsibility for their lives; employing a generalist rather than specialist perspective; fostering a therapeutic relationship based on

mutual co-operation; viewing the patient as one who acts on the environment rather than being determined by it; having optimistic faith in each patient's potential; encouraging patient productivity and participation; recognizing the healthfulness of play, leisure activities, and a balanced life; and seeking to understand the subjective perspectives as well as objective characteristics of patients and their worlds (Yerxa, 1983: 152-153).

Whilst all of these values will form the basis of the discussion within the rest of this chapter, two of the values will be discussed here in relation to this study.

Yerxa (1983: 153) proposes that occupational therapists encourage 'patient productivity'. This might be viewed as oppressive if productivity is taken in narrow terms and seen as reinforcing the historical oppression of the disabled as Oliver (1990) would see it, in terms of ability to be a productive member of the labour force and society. However, Yerxa (1983: 152) is using 'productivity' in a much wider context:

> occupational therapists value productivity and participation of the patient in the stream of life. Productivity is esteemed, not necessarily to benefit society economically, but rather as being intrinsically satisfying to the person. In this sense productivity is seen as engagement in that which has meaning for the patient.

The other value which has particular meaning in relation to this study is 'the appreciation of the subjective' (Yerxa, 1983: 152) as well as the objective.

Given this focus on the subjective or phenomenological it seemed appropriate that the focus of this study should be the subjective understanding of the student cohort as well as more objective measures of their attitudes towards disabled people.

DePoy and Merrill (1988) attempted to explore the process and nature of value acquisition during the process of professional socialisation into occupational therapy. They summarised the values of the profession, as enshrined in their occupational therapy curriculum, as:

> 1) humans are to be viewed as self-directed;
>
> 2) all persons have the right to the highest quality of existence;
>
> 3) humans are multifaceted complex systems that interact with the environment and accumulate subjective experiences;
>
> 4) the therapeutic process is an interaction between client, therapist and environment;
>
> 5) health is a dynamic balance of leisure, self-maintenance and productive participation in society (DePoy & Merrill, 1988: 260).

DePoy and Merrill found, not surprisingly, that on entry to their training, students were unable to articulate the values of their chosen profession. Their values focused on 'helping others'. The notion of helping was not defined in the occupational therapy concept of facilitating the person to achieve her/his own goals, but rather in terms of 'curing' or working with patients in a non-specific manner. These notions of 'curing' persisted during the first year of training. Whilst students appeared to be able to articulate the

values of their chosen profession, they were less able to put these values into practice when talking about intervention planning in class.

> Essentially, students seemed to take a technical approach in their intervention plans, an approach based primarily on the use of skills. They were unable to articulate the holistic nature of problems presented in the classroom and tended to focus on the disabled parts of patients ... students tended to concentrate on 'curing' the client (DePoy & Merrill, 1988: 267).

Within the current study students were presented with scenarios and asked about their intervention. It might be assumed that the interviews with the 1st year cohort would produce similar findings as those described above, with students focusing on the narrow problem rather than considering the wider social and environmental aspects of the problem.

By the time the students in DePoy and Merrill's study had reached their final year, they were found to be able to articulate the values of the profession, but they could not always see the relevance of these values in practice;

> students often indicated that practice based on Yerxa's values took more effort and was time-consuming, and that it was not practical to consider values in 'the real world' (1988: 268).

It will be interesting to see whether the students within the current study are able to articulate the values of the profession, in terms of holism, empowerment and choice, and how well they are able to put these values into practice as they reach the end of their occupational therapy training. Will they also be able to articulate values and concepts but fail to see their relevance

for practice in 'the real world'? If this is the case, it may be that the ideologies of the profession are not oppressive, but that the nature and constraints upon practice induce oppressive attitudes.

Yerxa outlined her 'audacious' values in 1983. Time has passed and the profession has continued to evolve. Have the values remained the same or have they evolved? If Yerxa's values are found to be inappropriate for practice in the 'real world' have new, less audacious values emerged? A group of faculty and graduate students at the University of Western Ontario attempted to articulate the values of occupational therapy (Polatajko, 1992). Their findings are outlined in Figure 3:1.

Figure 3:1. Occupational therapy values

As occupational therapists,
we value
- the individual
- human life
- occupation

About the individual,
we believe that humans are occupational beings, that:
- every individual has intrinsic dignity and worth
- every individual has the right to autonomy
- each individual is a unique whole
- each individual has abilities and competencies
- each individual has the capacity for change
- individuals are social beings
- individuals shape and are shaped by their environment

About human life,
we believe that all human life has value, that:
- the value of human life is based on meaning NOT perfection
- quality of life is as valued as quantity

About occupation,
we believe that occupation is a basic human need, that:
- occupation is an essential component of life
- occupation gives meaning to life
- occupation organises behaviour
- occupation has developmental and contextual dimensions
- occupation is socio/culturally determined

---

source: Polatajko (1992: 193)

It would appear from this summary (Figure 3:1) that the values of occupational therapy remain as audacious as Yerxa's original values. The focus is still on a unique individual who has autonomy and choice and has the right to a fulfilling life. Central to these values is the philosophy of practice and interaction within occupational therapy intervention. Recently the

profession has attempted to articulate this philosophy in the debate about 'client-centred' practice and caring.

Client-centred practice and caring

Gilfoyle (1980) proposes that there is both an art and a science of occupational therapy. The various models of health and practice, discussed above, can be seen as the foundations of the science of occupational therapy, providing the justification, understanding and ideas for therapeutic interventions. Gilfoyle proposes that 'caring is the primary technique inherent in the art of occupational therapy' (1980: 517). She defines caring as 'a process to facilitate growth and development of another person' (1980: 517). Thus,

> occupational therapy health care is an active relationship geared to helping another grow and actualize himself *(sic)* (Gilfoyle, 1980: 519).

However, this definition of caring, again, highlights the differing perspectives of occupational therapy and medicine. Within the traditional medical model, 'caring' can be seen as taking care of or giving care to a patient, with the patient as a passive recipient of care. 'Curing' can be seen as the removal of pathology and a return to normality. Within occupational therapy 'caring' involves an active relationship with the patient/client. The focus on purposeful activity and occupation means that the patient/client is no longer passive but an active participant within the therapeutic process. The therapeutic process involves the patient/client using activity to find purpose and meaning. Caring involves 'helping the person learn to take care of himself/herself' (Gilfoyle,

1980: 519). 'Curing' in occupational therapy draws on the notion of health through occupation and seeks to

> enhance people's abilities to adapt to their state of health and function within the environment. Curing involves helping people find meaning as they develop abilities that allow them to 'feel at home in their world' (Gilfoyle, 1980: 519).

Thus the success of an intervention must be judged from the patient/client's perspective, in terms of her/his perception of growth, development, self-actualisation, meaning and purpose, and 'feeling at home in the world'. The goals must be set and directed by the patient/client not by the therapist. The task of this study is to attempt to explore and map the development of this focus on the patient/client's goals. Caring in terms of 'doing things for' or 'looking after' and 'curing' were what DePoy and Merrill's (1988) 1st year students felt was what occupational therapy involved.

Peloquin (1990, 1993a, 1993b) analysed narratives and images of patients' interactions with occupational therapists and concluded that three images of occupational therapists dominated. The images were:

> the occupational therapist as a technician;
>
> the occupational therapist as a parent;

and

> the occupational therapist as a friend or collaborator.

The technician can be seen as the personification of occupational therapy within the medical model, focusing on technical issues and maintaining a professional, distant relationship with the patient.

> Although this image may seem cold, the basic impetus is humanitarian, because to the technical therapist only superior technical performance, efficiency, and use of correct procedure serve the patient's best interest (Peloquin, 1990: 17).

Intervention is based on diagnosis rather than on what the patient chooses or perceives to be important. The parent therapist has a more personal relationship with the patient and although this might be a positive, nurturing relationship the danger is that the therapist will

> threaten the patient's autonomy ... [by becoming] the over-authoritarian parent figure who wields power for the patient's own good (as defined by the therapist) (Peloquin, 1990: 18).

For the friend or collaborator therapeutic relationship, the focus is on trust, reciprocity and respect. This is the relationship of choice. Peloquin proposes that occupational therapists must 'recommit to the patient as a vital partner in a collaborative relationship' (1990: 13).

The focus on the patient/client's, rather than the therapist's, goals is a fundamental principle of client-centred practice. Although the idea of client-centred therapy has been part of the practice of various care professions, notably social work, for many years, drawing on the ideas articulated by Carl Rogers (1951), occupational therapists in Canada were one of the first groups of health care professionals to define and articulate a model of client-centred practice (Canadian Association of Occupational Therapists & Department of National Health & Welfare, 1983, CAOT, 1991). Law, Baptiste and Mills (1995: 253) have defined client-centred practice as

an approach to providing occupational therapy, which embraces a philosophy of respect for, and partnership with, people receiving services. Client-centred practice recognizes the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which a client lives.

The development, articulation and use of a client-centred model of practice by neophyte occupational therapists is the central theme of this research. Aspects of client-centred practice will become the themes explored within the interviews with the occupational therapy students in this study. The issues of autonomy, choice and partnership central to client-centred practice are also critical to our discussion of occupational therapy as an oppressive practice.

Client-centred practice assumes that the client has autonomy and choice in the intervention process. The client and not the therapist is seen as the expert.

> Clients are experts about their occupational function. Only they can truly understand the experience of their daily lives, express their needs and make choices about their occupations. (Law et al., 1995: 251)

Thus the client is much more involved in directing the intervention process and the client and the therapist work in partnership to define goals, decide intervention and identify the desired outcomes. The goals the client sets may be radically different from those the therapist might have set and this challenge to the ideas and power of the therapist may be difficult for students

to accommodate, and so may lead to them adopting more rigid medical model approaches to intervention and practice.

Occupational therapy and the independent living movement

The notion of partnership is central to the ideas of the independent living movement. In this section we will outline the philosophy underpinning the independent living movement and discuss the place and role of occupational therapy within that movement.

The development of the independent living movement in Britain and America follows a parallel course. In the 1960s and 1970s disabled people were seeking 'a more fulfilling life in the able-bodied world' (De Jong, 1981: 239) and 'greater control over their lives' (Morris, 1993: 17). This led to the development of Centres for Independent Living which 'aimed to provide advice and support to disabled individuals who wanted to live independently' (Morris, 1993: 20). Thus disabled people began to take control of, and become seen as experts in, their own needs. The Centres for Independent Living are described by Morris (1993: 20) as

> a system of services created by and staffed by disabled people, which could provide the magic of peer counselling and peer models.

The philosophical basis of the independent living movement is

> that disabled people have the right to personal and sexual relationships, to parenthood, mainstream education and employment (Tomlin, 1996: 4).

Morris (1993: 21) argues that this philosophy is based on four assumptions:

> that all human life is of value;
>
> that anyone, whatever their impairment, is capable of exerting choices;
>
> that people who are disabled by society's reaction to physical, intellectual and sensory impairment and to emotional distress have the right to assert control over their lives;
>
> that disabled people have the right to participate fully in society.

Whilst the development of the independent living movement is beyond the scope of this thesis, the key issues of control and a redefinition of independence are central to this study.

Redefining independence

Morris (1993:22) argues that independence

> has commonly been associated with the ability to do things for oneself, to be self-supporting, self-reliant.

This has meant that anyone (e.g. a disabled person) who cannot do things or support her/himself is seen as dependent, a second-class citizen and unable to control her/his own life. It has led to an

> ideology of independence. It teaches us that unless we can do everything for ourselves we cannot take our place in society. We must be able to cook, wash, dress ourselves, make the bed, write, speak and so forth, before we can become proper people, before we are 'independent' (Brisenden, 1989: 9, see also Corbett, 1989).

The notion of independence as performing functional tasks has also led to, what Turnbull and Turnbull (1985) term the 'fix-it' model of independence,

where the disabled person is helped (or rehabilitated) to fix or minimise her/his functional limitations by being given aids or adaptations and taught to perform functional tasks. This model focuses on the skills and processes of independence, often excluding or ignoring the quality, for the disabled individual, of the independent existence (Corbett, 1996)

The independent living movement challenged and rejected this model of independence and argued that independence is about control, autonomy and, most importantly, choice (see also Rock, 1988), and

> simply being able to achieve our goals. The point is that independent people have control over their lives, not that they perform every task themselves. Independence is not linked to the physical or intellectual capacity to care for oneself without assistance; independence is created by having assistance when and how one requires it (Brisenden, 1989: 9).

Wendell (1996) outlined four aspects, which she proposed as central to disability activists' definitions of independence. These four aspects are:

> not living in an institution;
>
> not being dependent upon the goodwill of family or friends for basic needs;
>
> being able to make decisions about how life will be lived;
>
> being able to do meaningful work.

These goals for independence can, however, marginalise and oppress disabled people just as much as the functional definitions.

Perhaps the best definition of independence is provided by Jane Campbell, who is herself disabled:

> if it takes me 4 hours to get dressed and undressed but only 20 minutes to do so with help, then I'd rather get help so I can go out and spend the rest of the 4 hours with friends. Independence to me is not the ability to get dressed on my own, but being able to participate in living (cited in Tomlin, 1996: 4).

The traditional rehabilitation model has limited value within the context of control and autonomy. The disabled person, within an independent living model, becomes an active consumer of services not a passive patient or client in receipt of care or therapy. Where does this leave the therapist? Jane Campbell proposes that

> they will have to learn a new way of working with disabled people and not focus on their functional inabilities (cited in Tomlin, 1996: 4).

The role of the professional in independent living or, as Campbell (1994: 90) prefers to call it, self-determination, is to

> give the best professional advice possible and facilitate that person to make an informed choice ... It is because disabled people need facilitation on the road to empowerment that your role is a vital one ... Be the true professional, work with the consumers, not for them or on their behalf ... working for radical change by our direction (Campbell, 1994: 90).

By using scenarios relating to patient/client interactions, this research is exploring how well student occupational therapists are able to facilitate and

work with rather than for their patients/clients. How well occupational therapists in practice have made the move towards an independent living model will be explored in the next section.

But before we complete our redefinition of independence it is worth noting Corbett's (1996: 1) definition and her discussion of inter-dependence. Corbett defines independence as:

> knowing what you want and being able to express individual needs;
>
> having a strong sense of self which recognises personal boundaries;
>
> having as much control over your own life as possible.

However, Corbett (1996) reminds us that the notion of independence should not be divorced from the notion of inter-dependence.

> To be fully alive as human beings requires a complicated inter-dependency upon networks of people and systems. Independence is not about coping without help of any kind. That describes a bleak existence (Corbett, 1996: 1).

The fact that the author has the financial resources to choose to employ someone to clean her house, which in turn allows her to utilise limited energy resources to conduct her PhD research does not mean that she is any less independent than someone who does her/his own cleaning. Exploring personal definitions of independence with the occupational therapy student interview cohort might provide illuminating insights into their interactions with patients/clients and their understanding of the complex relationship between independence and interdependence.

The place of occupational therapy in independent living

It might, on the face of things, appear that occupational therapy and independent living have much in common. The American Occupational Therapy Association (AOTA), on the role of occupational therapy in the independent living movement, states:

> the philosophy of the independent living movement parallels that of occupational therapy in that both advocate for the right of the individual to live as independently as possible in the community, and both work to promote environments and attitudes that will facilitate that process (AOTA, 1993: 1079).

The move towards a philosophy of client-centred practice and Peloquin's (1990) notion of the therapist as friend and collaborator with her/his patient/client, appear to match Campbell's (1994) notion of the professional's role as a facilitator who works with the client or consumer (see also Klein, 1996). However, these philosophies could still be based on an individualistic, personal tragedy notion of the problems of disability. Philosophies which run parallel may never converge and meet, they may be based on different concepts of the causes of the problems of disability.

Yerxa (1980: 532) highlighted the need for occupational therapists to move to a

> mutual co-operation model of therapist-patient relationship, in which the patient and therapist enter into a partnership, and in which patients have the authority to determine their own needs.

Yerxa goes on to argue that the problems of disability are social not personal and to highlight the role occupational therapists have in changing society to meet the needs of the individual, and to

> serve as advocates to assure that social consciences are reawakened and that society fulfils its obligations to those persons whose lives have been saved through technique (1983: 533).

The need for occupational therapists to adopt and work within a social model of disability is refined by Jongbloed and Crichton (1990: 37) as they outline the consequences for professionals if they do not adopt the social model:

> unless rehabilitation professionals become actively involved in supporting efforts by the disability rights movement to eliminate environmental and attitudinal bias and discrimination, there is a risk of separation between disabled citizens and professionals.

Cooper and Hasselkus (1992), in a study aiming to develop design guidelines for housing suitable for independent living, found that control was the central issue which overrode consideration of safety, access or privacy. They go on to consider how this might affect the role of the occupational therapist:

> while in the past this has usually meant a focus on function and the use of adaptations that promote ADL *(activities of daily living)*, for many of the individuals trying to cope with IL *(independent living)* such goals may be too limited and perhaps even unrealistic; the more important issue in the future may be to foster as many facets of environmental control as possible ... the focus of intervention is developed and driven by the patient's self-perceived needs (Cooper & Hasselkus, 1992: 14).

The growth of independent living led AOTA to issue a statement on the role of occupational therapy in the independent living movement which 'asserts that occupational therapy practitioners can serve a vital role in independent living programs' (AOTA, 1993: 1079). However, in further expanding and outlining the role of occupational therapy the statement appears to be somewhat ambivalent about how far the occupational therapist should adopt a social model approach or change the power relationship in favour of the client:

> in the independent living movement, the consumer identifies his or her own goals. Responding to the consumer's stated needs, and in collaboration with the consumer, the occupational therapy practitioner *observes and assesses the consumer's capacity to perform various activities*, considers the demands of the environment, and assists the consumer in accomplishing these goals. The focus is on *adaptation and modification of the consumer's strategies* and the environment rather than the remediation of an underlying impairment. (AOTA, 1993: 1079) *(emphasis added)*

This sense of ambivalence is also present in Frieden and Cole's (1985) discussion of the rehabilitation of people following spinal cord injury. They see independent living as a stage, possibly the final stage, of the rehabilitation process. They argue that occupational therapy has a role in all phases of the rehabilitation process from the restoration of function, through re-ablement, to independent living. Whilst they appear to acknowledge the

social barriers to independence (environmental and economic) they also outline personal barriers to independence:

> examples of such barriers include negative attitudes, low self esteem, feelings of dependence, unreasonable insecurity, unwillingness to take risks, preoccupation with cure, the inability to organize and plan, poor self-image, and unnecessarily limited expectations and goals (Frieden & Cole, 1985: 735-6).

In outlining the occupational therapy role within independent living, Frieden and Cole (1985) mention ways of addressing the economic and environmental barriers, but the main emphasis is on helping the individual deal with the problems; a personal tragedy approach, rather than a social model approach. They argue that

> the therapist's principle role be one of support in helping the client learn to solve problems related to his or her interaction with the environment as opposed to directing therapeutic activities designed to restore certain of the client's abilities. This is not to say that restorative activities are not important but that there is sometimes far too much emphasis placed on changing the person as opposed to helping the person adapt to the circumstances. (Frieden & Cole, 1985: 738)

A contrasting and unambivalent stance is taken by Schlaff (1993). She focuses entirely on a social model approach to disability and proposes that occupational therapists have a role to play in, what she refers to as, the redefinition of disability. She argues that occupational therapists should become 'advocates who facilitate changes in the environment that increase

opportunities for persons with disabilities' (Schlaff, 1993: 943). But before occupational therapists can become advocates they must 'educate themselves about their own attitudes and behaviors with respect to disability rights' (p948). They must find out about disability from the perspective not just of the disabled person, but also the disability activist, only then will they be able to redefine disability as a social rather than an individual problem.

A key area where occupational therapy intervention can demonstrate client-centred practice and a focus on the patient/client's needs is the assessment process. Mountain and Moore (1996), however, demonstrated that occupational therapy assessment was often perceived more as a test than an opportunity to discuss needs. They found that occupational therapists working in health care were entrenched in the medical model and tended to make decisions for their clients rather than enter into a collaborative needs-focused dialogue. One assessment tool which has attempted to redress the balance is the Canadian Occupational Performance Measure (COPM) (Law, Baptiste, McColl, Opzoomer, Polatajko & Pollock, 1990). The COPM is a treatment outcome measure which uses the patient's self-evaluation of her/his occupational performance in the areas of self-care, productivity and leisure. Occupational performance is measured not only in terms of ability to perform a task, but also in terms of the patient's satisfaction with her/his performance of the task. However, as Ward, Jagger and Harper (1996) found in their study of elderly patients with hip fractures, the COPM is far from an ideal tool. Their study highlighted a common problem; therapists tend to identify more problem areas and needs than do their patients, and if this is

the case, whose judgement should the therapist rely on? Ward, Jagger and Harper (1996: 452) also found that 'patients expressed concern about a wider range of activities, while the therapists focused on basic ADL skills'. The COPM should, however, help therapists to establish the patient's priorities and goals. This study will explore how important student occupational therapists perceive the patient's priorities and goals to be.

It appears from this review of occupational therapy and independent living that occupational therapy is trying to work within an independent living framework, but not always succeeding. The predominant focus on personal tragedy definitions of disability may result in occupational therapy being an oppressive profession.

An oppressive profession?

It is the contention of this author that occupational therapy has the potential both to empower and to oppress disabled people. The focus of this study is to explore these issues in practice. The focus of this section is to use the literature and research to explore these issues.

Occupational therapy values, attitudes and practice might be seen as the characteristic way of thinking of occupational therapists. To be oppressive, this way of thinking must be based on an imbalance of power between the therapist and the patient/client, on issues of control and of keeping the main patient/client group, i.e. disabled people, in a subservient position. In terms of disabled people, the subservient position could be seen as the personal

tragedy image of disability. The dominant groups and values in terms of occupational therapy can be seen not only as the bourgeoisie, the work ethic and the need for productive labour, but also medicine and the medical model and the social oppression of disabled people. By turning disability into the individual's problem, by assuming that they as the therapist know best and by focusing intervention on functional independence and returning to useful productivity, occupational therapists might be seen as adopting and working within an oppressive profession.

Abberley (1995) certainly sees occupational therapy as an oppressive, or as he terms it 'disabling', profession. Abberley argues that occupational therapy does not incorporate a social model of disability into its practice but has an ideology in conflict with it. He reinforces his argument with analysis of data from a small, qualitative, study of occupational therapy, in particular the ways occupational therapists explained success and failure of interventions. Successful occupational therapy was defined by two criteria:

> one is client satisfaction, the other therapist defined performance criteria. The two generally interact, and sometimes contradict. Where this occurs the contradiction is resolved in favour of the therapist, and the adjustment of the client's view of reality is seen as part of the therapy task (Abberley, 1995: 227).

Failure is explained in three ways: in terms of actions by the therapist, although Abberley states that this was an infrequent response; attribution to forces beyond the occupational therapist's control, e.g. lack of finance or 'the system'; or the client. Thus the occupational therapist is to blame if

intervention is successful and the client is to blame if it is not. This idea is also the central tenet of Etherington's (1990) article on the occupational therapist as counsellor for attitude change with her/his disabled clients. She proposes that

> whilst working with people with physical disabilities, occupational therapists frequently become aware of the need for unhelpful attitudes to change in order for the person to live more effectively (Etherington, 1990: 463).

She goes on to use case studies to illustrate how counselling (which, arguably, is not an occupational therapy core skill) can be used to help clients change their unhelpful or dysfunctional attitudes and help 'the individual's progress in his *(sic)* coping with [rather than] succumbing to disability' (Etherington, 1990: 464). Both of these papers would certainly appear to reinforce the notion of occupational therapy as an oppressive profession.

Hasselkus and Dickie (1994: 145) also explored success and failure in terms of 'what is the nature of satisfying and dissatisfying experiences in occupational practice?' Of their three analytical categories of craft, community and change it is the change category that is most relevant here. Satisfaction was 'strongly linked to regaining capabilities and social contexts that existed for the patient before the disability' (Hasselkus & Dickie, 1994: 147). The narratives that Hasselkus and Dickie report use terms like 'struggle' and 'persevere', 'therapists will try and try to bring about that expected ending' (1994: 148). The emphasis, in common with Abberley (1995), is on the

skills and abilities, should mean that occupational therapists work to enable and empower disabled people. However, we have noted the potential conflict of definitions of independence between occupational therapists and disabled people, and the focus on the individual adapting and changing in response to their environment, which implies a much more oppressive practice.

Occupational therapy intervention is complex and is often driven not just by the client's needs but also by the context of practice and the stage of the rehabilitation intervention. The nature of the intervention and the focus of occupational therapy as oppressive or empowering will change as the client's rehabilitation develops. It is possible to locate interventions within the various models of disability discussed in the previous chapters. Using Burrell and Morgan's (1979) paradigm framework (Figure 3:2) it is possible to conceptualise how approaches to intervention might change throughout the intervention process, which models the various interventions might be located within and whether the intervention might be perceived as being empowering or oppressive.

success being due to the therapist's efforts. Dissatisfaction is expressed in terms of 'battles lost' and the

> therapist's sense of being unable to bring about any change or as much change as originally hoped for, or bringing about improvement but having that change subsequently undone (Hasselkus & Dickie, 1994: 147).

The reasons for these failures or lack of change have similarities to those Abberley (1995) identified, but also key differences. The reasons Hasselkus and Dickie (1994) found were: the therapist's lack of skill; inability to persuade the patient, the family or the management of the value of treatment; problems with the system; problems with the patient, either plateau-ing sooner than expected, initially improving but then not maintaining that improvement, or dying; and actually causing harm to the patient. Whilst the idea that the patient might be to blame for the failure is present, it does not seem to be as central as Abberley maintained. The notion of success and failure of intervention is an interesting one and will be explored within the interviews with the occupational therapy student group.

Conclusion

Having explored the values of occupational therapy and looked at occupational therapy in relation to both the medical/rehabilitation models and the Independent Living/social models, it must be concluded that occupational therapy has the potential to both oppress and empower disabled people. The values of occupational therapy and the development of client-centred practice, with a focus on autonomy, meaningful occupation and the client's

Figure 3:2: Paradigms and models of occupational therapy intervention

radical change: empowerment

independent living model	***social model***
s u b j e *consumers* *advocacy and peer support* *self directedness* *removal of barriers*	*political activism* *changing society* *addressing attitudes* *influencing social policy* **o b j e c**
c t i v e *individual problem* *focus on functional ADL* *e.g. dressing independently* *provision of aids and adaptations*	*treatment of symptoms* *e.g. activities to increase range of movement* *individual's problem* **t i v e**
rehabilitation model	***medical model***

regulation: oppression

Using the example of an individual with a spinal cord injury following a road traffic accident it is possible to illustrate how OT intervention can progress from a medical to a social model of practice. When the individual is admitted to a Spinal Injury Unit s/he will be confined to bed (possibly in skull traction) whilst the spine can begin to heal. At this early stage any OT intervention may be confined to a medical model (or biomechanical) approach, using activities to maintain and strengthen movements. Once the person begins to mobilise, the focus of OT intervention will move to a rehabilitation approach,

dealing with functional activities of daily living and independence and practical ways of overcoming disability. As the person prepares to leave hospital and return to the community the focus of intervention should be on an independent living approach, where the intervention is client-driven and the goal is to facilitate independence as defined by the client. Once the person has returned to community living any OT intervention should be driven by a social model approach, working with the person to address oppressive practices within the social environment and social institutions.

The overwhelming flavour of the occupational therapy literature which has been reviewed and discussed in this chapter is of a profession which is beginning to acknowledge and question the oppressive nature of the medical model, to move towards a client-centred model of practice, and to begin to address issues dealing with the role of occupational therapy within a social model of practice. This research aims to explore how far this has influenced the ways occupational therapy students conceptualise their practice with disabled people. This chapter has served to provide an overview of the ideas/ theories/models that underpin OT. It, therefore, provides the background for the professional behaviour and attitudes of the profession into which these students are being socialised.

Chapter 4

ATTITUDES TOWARDS DISABLED PEOPLE:

EXPRESSIONS OF EMPOWERMENT OR OPPRESSION?

One of the aims of this study is to explore the 'meaning' of disability amongst OT and non-OT students. The perceptions and images, discussed in the previous chapters, demonstrate the meaning of disability within contemporary society. One way of exploring what this meaning is for individuals is through an exploration of research into attitudes towards disabled people. This chapter will explore the nature of attitudes, the research on attitudes towards disabled people with particular focus on the effect of contact on attitude change and the existing research on the attitudes of health/rehabilitation professionals towards disabled people. The chapter will also outline how attitudes can be used to explore empowerment and oppression of disabled people amongst OT students by discussing the nature of empowering and oppressive attitudes.

The nature and function of attitudes

The term 'attitude' is notoriously difficult to define, but key aspects from definitions (Ajzen & Fishbein, 1977, Gross, 1992, Oppenheim, 1992) would appear to be that attitudes have an affective and evaluative component. 'The evaluation dimension has frequently been regarded as the most distinctive factor of attitude' (Ajzen & Fishbein, 1977: 888). Attitudes are about the ways people feel towards other people or things. Attitudes are also linked to behaviour. They are 'predispositions to respond' (Gross, 1992: 515). In other words, understanding someone's attitudes towards a particular group of

people (e.g. the disabled) will not only tell us what s/he feel and thinks about that group but also how s/he might act towards members of that group and whether those actions are likely to be empowering or oppressive. Attitudes are also 'learned' (Gross, 1992: 515). Thus the way an individual feels and behaves towards a particular group of people is based on past experience. We will explore later in this chapter how the effects of contact, as a particular type of experience, have been shown to influence attitudes. Learning may include more than just actual experience; it may also include the whole process of socialisation into membership of a particular group.

Ajzen and Fishbein (1977: 914) locate attitudes within a conceptual framework of beliefs, attitudes, intentions and behaviours:

> beliefs are the fundamental building blocks in [this] conceptual structure ... The totality of a person's beliefs serve as the informational base that ultimately determines his *(sic)* attitudes, intentions and behavior ... a person's attitude towards some object is determined by his beliefs that the object has certain attributes and by his evaluation of those attributes.

A person's beliefs will affect his/her attitudes, which will in turn affect behavioural intentions. Thus an individual may see disabled people as 'brave', 'in need of help', 'of limited intelligence' and 'capable of learning new skills'. These beliefs may lead the person to hold a positive attitude towards disabled people. This attitude leads to a set of intentions which are positive and which will result in certain behaviours such as becoming an OT, talking slowly and deliberately to any disabled person they come into contact with, or

choosing to work with a youth group for disabled teenagers. Behaviours will also be determined by the beliefs and definitions of disability (Altman, 1981). Thus, if disabled people are 'in need of help' they will be given help and, therefore, beliefs of the dependency, and the disempowerment and oppression, of disabled people will be reinforced. These 'positive' attitudes may also serve to reinforce the personal tragedy model of disability and so someone holding these attitudes might not accept the social model view of the need to change societal views of disabled people. The nature of 'positive' attitudes towards disabled people will be explored later in this chapter.

How are attitudes measured?

Attitudes can be measured in a variety of different ways, for example by interview, by questionnaire or by the use of projective techniques. This section will focus on the use of questionnaires and attitude scales as a way of analysing and comparing people's attitudes. After a brief overview of a number of attitude scales, attention will focus specifically on the measurement of attitudes towards disabled people. Attitudes are often perceived as straight lines (Oppenheim, 1992) and so measurement allows us to locate an individual somewhere on a linear continuum from highly positive, through neutral, to extremely negative. Although this might be a simplistic notion, it is a useful activity, especially if seen as allowing comparisons between groups of people, such as OT students and non-OT students. The best known methods of attitude scaling are the Bogardus (or social distance), Thurstone, Likert, Guttman and semantic differential scales. We will focus on social distance, Likert and semantic differential scales as

these have been the most commonly used scales in disability attitude research, and are the methods employed within this study.

Social distance scales

This method of attitude measurement was originally designed, by Bogardus (1925), as a measure of racial prejudice. Respondents were asked how willingly they would admit members of particular racial groups (e.g. Canadians, Chinese, French) (Oppenheim, 1992) to various degrees of 'social distance':

> to close kinship by marriage;
>
> to my club as personal chums;
>
> to my street as neighbours;
>
> to employment in my occupation;
>
> ... would exclude from my country (Oppenheim, 1992: 189).

There is an implicit assumption of linearity from marriage at one end to exclusion at the other end of the scale. Although for some people employment might imply a closer social distance than a neighbour might.

Likert scales

This is probably the most commonly used and popular attitude scale (Gross, 1992, Oppenheim, 1992). Questionnaires using a Likert scale give respondents a series of statements about the attitude object to which responses are made on a scale of strongly agree, through undecided, to strongly disagree. Each response is given a score and the total score for each question is calculated. The biggest problem with Likert scales is their

'lack of reproducibility ... the same total score may be obtained in many different ways' (Oppenheim, 1992: 200).

Semantic differential scales

Semantic differential scales were originally devised by Osgood, Suci and Tannenbaum (1957) as part of the quantitative analysis of meaning. Respondents are given a series of bipolar adjectives and asked to rate an attitude object along a response scale. A seven-point scale is seen as optimal (Oppenheim, 1992), although three- and five-point scales are also used. The adjectives used represent three factors, evaluation, potency and activity.

Measuring attitudes towards disabled people

Altman (1981) identifies four aspects of attitudes towards disabled people which have been focused on: affective components; conceptions or cognitions; social distance; and ranking different types of disabling conditions. Her distinction, however, between affective and cognitive component research is unclear. Yuker, Block and Younng (1970: 4) argue that all attitude research (including the ATDP [Attitudes Towards Disabled People Scale]) provides a 'continuum of acceptance - rejection or positive - negative affect'. The ATDP is thus located within the affective component, whilst Altman (1981) classifies it under cognitive aspects.

The Attitudes Towards Disabled People Scale

The most popular research tool appears to be the Attitudes Towards Disabled People Scale (ATDP), devised by Yuker, Block and Campbell (1960) (Altman, 1981, Yuker et al, 1970, Speakman, 1989, Livneh, 1982). The ATDP was designed because there appeared to be nothing available to measure adequately attitudes towards disabled people. Its aim was 'to provide an adequate positive - negative scaled measure of attitudes towards the disabled with evidence of reliability and validity' (Yuker et al, 1970: 17). The ATDP is a relatively short Likert scale questionnaire. Its focus is on attitudes towards disabled people in general, although it can, and has, been used to address attitudes towards specific disabling conditions (e.g. Furnham & Pendred, 1983). Although data from the ATDP are generally seen to represent attitudes as a single score, the items on the scale can be divided into two types. Some items are to do with the perceived 'characteristics' of disabled people and how similar they are to non-disabled people. Other items reflect the respondent's view of whether disabled people should be treated in the same way as non-disabled people. Yuker et al (1970), however, argue that the ATDP should not be split into sub-scales and should be seen as a unidimensional measure. The explicit assumption with the ATDP is that a positive attitude towards disabled people is one which indicates that disabled persons are not "different" from non-disabled persons. This assumption has been questioned (Altman, 1981). In the light of notions of 'celebration' of disability (Corbett, 1994) and the emphasis of disability activists on their disabled identity, it may be seen as erroneous to assume that a positive attitude implies that disabled people are just the same as anyone else.

However, for all its critics (e.g. Altman, 1982; Antonak, 1980; Siller & Chipman, 1964; Makas, Finnerty-Fried, Sigafous & Reiss, 1988; Livneh, 1982; Speakman, 1989), it is the most widely used measure of attitudes towards disabled people and has, therefore, been included as one of the quantitative measures within this study.

Social Distance Scales

The idea that disabled people can be perceived as 'not quite normal', 'sub-human', or 'childlike' has already been discussed. These perceptions can lead to responses of pity, guilt, rejection or discomfort when a non-disabled person comes into contact with a disabled person. This in turn could effect the social distance and closeness of social relationships an individual might wish to have. Albrecht, Walker and Levy (1982) used a modified Bogardus scale to measure perceived social distance from individuals with a variety of physical and social disabilities and stigmatising conditions. They found that the anticipated disruption to social interaction was the most significant factor in establishing social distance, irrespective of the cause of or responsibility for the stigmatising condition:

> not knowing how to interact with a paraplegic can be just as disruptive as fearing that association with an ex-convict will taint your character. In the same manner, encountering a grotesque disfigurement that offends a sense of aesthetics may be as disruptive as having to face disparity between your own good health and another's functional incapacity (Albrecht et al, 1982: 1325).

Other measures of social distance have been used to explore these issues of discomfort. A common method, especially with children, has been to show pictures of disabled and non-disabled people, or dolls, and ask 'would you like this girl/boy to be in your class/sit next to you/be your friend' (e.g. Bracegirdle, 1992; Freeman, 1988). Social distance scales have also been used to measure attitudes to disabled people in general (Freeman, 1988, Bowman, 1987) and to different disability groups among different ethnic groups (Westbrook, Legge & Pennay, 1993).

Tringo (1970) drew on ideas of social distance to develop his Disability Social Distance Scale. He used a 9-point scale from 'would marry' to 'would put to death' to compare attitudes towards different disability groups. Drawing on previous research into racial prejudice, Tringo proposed that not only would there be prejudice against disabled people in general, but that specific disabilities would be seen either more or less negatively and it would be possible to create a hierarchy of preference towards disability groups. Little work appears to have been done to explore the validity and reliability of this scale, although the scale has been used in researching OT students' attitudes (Lyons & Hayes, 1993).

Semantic differential scales

Just as the ATDP can be seen to ask respondents about characteristics of disabled people, so semantic differential scales can be used as a way of accessing views on the characteristics of the attitude object. Freeman (1988) used a semantic differential scale which drew its adjectives from the

perceptions of disabled people outlined by Kurtz (1981) and discussed in the previous chapter. She used the scale to explore concepts and stereotypes of disabled people in a group of undergraduate students. St Claire (1986) developed an 80-item semantic differential scale to compare lay and professional constructs of mental retardation. Her adjectives also drew on common perceptions and beliefs about disabled people. Whilst the construction of semantic differential scales has varied and does not, therefore, lend itself to comparative analysis with other research, it is a useful tool for exploring the constructs, beliefs and stereotypes which groups of respondents hold about disabled people. A semantic differential scale has, therefore, been included as one of the tools used in this study not only to compare constructs between OT and non-OT students, but also to explore the constructs held by OT students in relation to whether they empower or oppress disabled people.

Positive attitudes - what are they?

It is, possibly, easier to define negative responses to disabled people than positive attitudes. Gething (1992, also Yuker, 1977, Yuker & Block, 1979) categorised these negative responses as

a) fear of the unknown and anxiety of not knowing how to behave towards a disabled person, or what to expect from them;

b) a threat to one's security, because a world which has been perceived as fair and just cannot be so if disabled people are seen as 'suffering' from an unjust fate;

c) vulnerability and fear of becoming disabled and how one would respond;

d) guilt because one is not disabled;

e) disability as a tragedy;

and

f) an aversion to weakness.

There are also feelings of guilt mixed with curiosity about the nature of the disability and a tendency to stare or respond unnaturally. Soder (1990) argues that this is due to ambivalence or approach-avoidance conflict rather than prejudice or negative attitudes, although, as Yuker and Block (1979: 19) point out, 'few people publicly report negative feelings about disabled people'. It is not socially acceptable to say negative things about disabled people and yet, as we have shown, disabled people are disadvantaged and oppressed. Disabled people are being responded to negatively.

Research into attitudes towards disabled people has shown that disabled people are stereotyped not only as 'different' from non-disabled people, but also as dependent, isolated, depressed/sad and emotionally unstable (Altman, 1981). Furnham and Pendred (1983) also found that disabled people were seen as socially introverted and hypersensitive. Yuker (1976), summarising attitude research, stated that disabled people were seen as difficult and inferior, they made non-disabled people feel uncomfortable and that the majority of non-disabled people were in favour of some form of segregation of disabled and non-disabled, either in terms of education, domestic arrangements or social interaction.

Freeman (1988), using a semantic differential scale, found disabled people were perceived as disadvantaged, dependent, of low status and unlucky. However more positive (or politically correct) responses were also made. These included bright, pleasant, sensible, respected and normal. Freeman notes a conflict of results with the terms physically deformed, clumsy and uncontrolled being avoided on the semantic differential and yet impairment and abnormality being key terms used when respondents attempted to define the term disability. This finding highlights a problem that may exist with the respondent group of this study, as Freeman (1988: 106) put it; 'there seems to be almost a squeamishness about subscription to these terms'.

Effects of age, gender and social class on attitudes

Key independent variables within research into attitudes towards disabled people have been age, gender, education and socio-economic status. Yuker and Block (1986), in their review of research using the ATDP, report equivocal results on the effect of age on attitudes. Some studies have found a positive correlation between age and positive attitudes whilst other studies have found a negative correlation. It is highly likely that any relationship between attitudes and age is confounded by other variables.

The effect of gender on attitudes also seems unclear. Of the 129 studies, which included gender, reviewed by Yuker and Block (1986) 44% reported women as more positive than men, 5% reported men as more positive than women, and 51% reported no statistically significant difference in the results. Furnham and Pendred (1983) also found no significant difference in the

attitudes of men and women to any of their four disability groups. Yuker and Block (1986: 9) propose that there is a 'clear trend towards fewer gender differences in attitudes'. Although they do note that English, as opposed to American studies have shown gender differences in favour of women.

The two variables which probably confound the age and gender results are education and occupation. Yuker and Block (1986) argue that there appear to be positive correlations between higher education and positive attitudes. The effect of occupation is even more complex. In some cases there are differences attributable to occupation. However as Yuker and Block (1986, p10) point out,

> the most significant question concerns the attitudes of persons who work in the helping professions. Although many people believe that persons in the helping professions ... have positive attitudes, the data indicate that attitudes of professional helpers are often more negative than those of lay persons.

This research, which is of central importance to this study, will be reviewed in the final section of this chapter.

Attitudes towards specific disability groups

Research into attitudes towards disabled people has focused on both disabled people in general and on specific disability groups. In reviewing the literature on attitudes towards people with specific disabilities, Yuker and Block (1979) noted a hierarchy of acceptability. They proposed five categories of disability. The most acceptable, category I, consists of people

with partial and invisible disabilities, such as asthma or heart disease. Category II was partial but not substantial conditions, for instance someone who was paralysed but mobile in a wheelchair. Category III was loss of a major sense, blind, deaf. Category IV was mental illness and the least acceptable, category V was people who were mentally retarded or had brain and neurological damage.

Furnham and Pendred (1983) attempted to explore differences in attitudes towards different disabilities further. They used the ATDP to determine whether attitudes differed according to the visibility of the disability, and whether the disabilities were physical or mental, using a totally blind person, a totally deaf person, a person with Down's syndrome and an educationally subnormal person as their four disability types. Although they found that the mental handicaps (Down's syndrome and educational subnormality) were perceived significantly more negatively than the physically disabled people, the visibility of the disability did not yield significant differences in results. However it might be argued that whilst Down's syndrome and blindness may be visible, they are not highly visible or highly 'deforming' conditions. Conditions such as achondroplasia or spinal injury might be more 'visible' conditions and might produce different responses.

Using a social distance scale, Bowman (1987) looked both at attitudes to disabled people in general and attitudes towards specific conditions. He identified 3 preference groups which are somewhat different to those of Yuker and Block (1979). In his 'most preferred' group Bowman listed former

alcoholics, blind and paraplegic people. Least preferred were former mental patients, the mentally retarded and people with cerebral palsy. The middle group included epileptics, the facially disfigured and the deaf. In terms of disabled people in general, his social distance results were: would work with (97%); would vote for in a national election (87%); would be a roommate (75%); would date (58%); and would marry (48%). For specific disability groups the percentage responses for 'would vote for' was closer to 'would be a roommate' rather than 'would work with'; and for some groups (former alcoholic, deaf person, former mental patient and mentally retarded person) his respondents would rather 'room with' than 'vote for' them. He also asked about perceived ability to work, and found that former alcoholics and the facially disfigured were seen as most competent, and people with cerebral palsy or who were mentally retarded were the least competent, to work.

Tringo (1970), using his Disability Social Distance Scale, found a consistent hierarchy of preference across a range of subject groups from undergraduates to rehabilitation workers. The hierarchy divided, roughly, into four groups in order of preference: physical disability; sensory disability; brain injury; with mental handicap/illness last. Some anomalies existed, however, TB (a physical illness) was ranked 17 (21 was the most negative ranking) possibly due to the perception of contagion attached to TB, which might be paralleled by AIDS today. Similarly physical disabilities that might be sees as disfiguring or un-aesthetic, dwarf and hunchback, were ranked 14 and 16 respectively

Westbrook et al. (1993), as well as looking at cultural variables in social distance, attempted to replicate stigma hierarchies in terms of disabling conditions. They concluded that stigma hierarchies were remarkably stable both over time and across cultural groups. With slight variations their findings are similar to those of Tringo (1970), Yuker and Block (1979) and Bowman (1987). Most accepted were diabetes, asthma, arthritis and heart disease and least accepted were alcoholism, cerebral palsy, mental retardation, psychiatric illness and AIDS.

The effect of contact on changing attitudes towards disabled people

The central focus of this research is how the attitudes of OT students towards disabled people change throughout their 3 year BSc course. The variable which appears to have the greatest effect on attitudes towards disabled people is contact and interaction with disabled people (Altman, 1981; Yuker & Block, 1986; Furnham & Pendred, 1983). However the *nature* of that contact is seen as being crucial to the effect on attitudes (Yuker & Block, 1986; Furnham & Pendred; 1983, St Claire, 1986). This section will discuss the research on the effects of contact and other research on changing attitudes towards disabled people.

Donaldson (1980) and Yuker and Block (1979) have identified various techniques that have been utilised in investigations of changing attitudes towards disabled people, they include: direct contact with, or exposure to, disabled people; information about disabilities; persuasive messages; disability simulations and role playing; and discussion groups. Given the

nature and scope of this research, discussion will concentrate on contact; information/discussion; and disability simulation.

Contact with disabled people

In reviewing the previous research, Donaldson (1980) found that various methods and forms of contact had been used. Contact with disabled people was deemed to be either 'structured' or 'unstructured'. Structured contact involved direct contact through talks and presentations or indirect contact through the use of video presentations by disabled people (Donaldson & Martinson, 1977), whilst unstructured contact was social contact or random interactions. Donaldson argued that studies involving structured contact consistently resulted in positive attitude change whilst the results from unstructured contact studies were equivocal. This is supported by Roper's (1990) findings that acting as a volunteer at a Special Olympics did not necessarily change attitudes towards disabled.

The key factor within the contact situation appears to be the status of the disabled person. The disabled person must be seen as of equal status to the non-disabled person:

> equal relationships may be defined as those in which the handicapped individual is of approximately the same age as the nondisabled person and/or is approximately equal in social, educational or vocational status (Donaldson, 1980: 505).

The disabled person should also not 'act in a stereotypic manner' (Donaldson, 1980: 507). One of the problems of unstructured contact, Donaldson (1980: 507) perceives is

> the inherent disadvantages of possible exposure to persons who represent stereotypic images, or of inadvertent reinforcement of a previously held stereotype.

Thus contact might be seen to reinforce images of helplessness, hopelessness and dependency.

As well as the key factors of equal status contact and an opportunity to disprove stereotypic assumptions, Roper (1990) adds co-operative inter-dependence, support by authority figures and opportunities to interact as the vital features of contact if attitudes are to be changed. The emphasis on opportunities to interact runs somewhat counter to Donaldson's (1980) notion of the value of structured as opposed to unstructured contact. She argued that unstructured contact was not an effective technique for changing attitudes and yet interaction is more likely to take place within unstructured rather than structured contact. To these factors Yuker and Block (1979) have added co-operative rather than competitive interaction, the level of intimacy between disabled and non-disabled, the frequency of contact and societal and institutional support. The positive effects of contact which was both structured and co-operative was demonstrated in Desforges, Lord, Ramsey, Mason, Van Leeuwan and West's (1991) study of attitudes towards people with a history of mental health problems. A further influential factor is, what Rothbart and John (1985: 83) term, 'indirect "atmosphere" effects'. These

would include the attitudinal climates which can be seen in the support of authority figures and also in norms and laws, 'images promulgated by parents, peers and gatekeepers as well as expectations' (Rothbart & John, 1985: 83).

The role of co-operative interdependence and support by authority and atmosphere effects are interesting with respect to the contact OT students might have with disabled people as patients/clients whilst on Fieldwork placement. Whilst on placement the OT student is in a very intimate learning relationship both with her/his supervisor and with her/his patients/clients. This learning relationship might be perceived as co-operative interdependence in that although the student is treating the patient/client, she is also learning from them, about their condition, about how to deal with and interact with people, and about her role as an OT. This might counter-balance the negative effect of the dependency of the patient. Possibly more significant, however, is the role of authority as embodied by the clinical educator, or Fieldwork supervisor, who as a qualified OT, may be seen as a significant role model for the student. The perceptions of the supervisor, in terms of adoption of a medical or social model of disability might be the crucial factor in how the student OT's perceptions of disabled people develop. A student arrives on Fieldwork placement full of ideas and expectations of what to expect, based on what she has learnt in the college-based modules. These ideas will influence the ways she interacts with her patients/clients and again may mitigate for, or against, a change in attitudes towards disabled people as a result of placement experience.

The reasons that contact with disabled people works and produces more positive attitudes is because it reduces discomfort, unease and uncertainty about interacting with disabled people and it contradicts stereotypes and, therefore, by creating dissonance, allows attitudes to change. Rothbart and John (1985) argued that the effect of the situational context would influence whether or not the stereotypic images are disconfirmed. Thus seeing a disabled person in the dependence-reinforcing situation of a hospital will only serve to reinforce stereotypic notions of dependence. Conversely the more atypical the member of the 'outgroup' (i.e. disabled people) the less likely they are to achieve 'goodness of fit' with the existing notions of the outgroup, but this will only serve, again, to reinforce the stereotype. Meeting a disabled activist, who opposes all stereotypical notions of helplessness, hopelessness and dependence, may result in antagonism and rejection of their ideas rather than a positive change in the image of disabled people and their need for civil rights. Rothbart and John (1985) propose that the most effective contact is with someone who achieves a 'goodness of fit' with the image of the outgroup but who has one or two stereotype challenging traits.

The level of contact might also be influential in the nature of attitudes towards disabled people. Although, as Altman (1981) noted, the operational definition of 'contact' has been wide-ranging and somewhat non-specific, and of limited validity and reliability. Three types of contact study appear to have been carried out, which use 'contact' in different ways (Yuker & Hurley, 1987):

i) experimental studies, where contact is the independent variable and is artificially manipulated;

ii) quasi-experimental studies involving comparison of two different groups where contact is assumed to be different, e.g. students at integrated and non-integrated schools;

iii) studies where previous contact is measured in some way.

Yuker and Hurley (1987) attempted to design a valid and reliable measure of contact. They proposed the use of the Contact with Disabled Persons scale (CDP), a 20-item Likert scale questionnaire. The scale demonstrated a limited positive correlation with ATDP scores and they were forced to conclude that the effects of contact on attitudes towards disabled people are highly complex.

Yuker and Block (1979) have noted that the greater the level of intimacy of contact (i.e. family member rather than work colleagues, friend or minimal contact), the more positive the attitudes. They also noted that the greater the frequency of contact the more positive the attitudes. However, Roper (1990) found that respondents with 'family' contact had less positive attitudes than respondents with 'friend' contact. Weinberg (1978: 121) found that people with little contact with disabled people see them as

> less interactively attractive, less happy, more self-controlled, "more good", more dependent, and more politically conservative than the able-bodied person.

These findings may be important when comparing the semantic differential results of this study, especially when looking at the non-OT student results. However, Weinberg (1978: 123) found that whilst attitudes towards disabled people became less stereotypic as contact intensified, 'a very intensive

contact situation is needed to effect a major change in perceptions of the disabled'.

One of the ways in which OT education seeks to influence students' attitudes is through contact with disabled people. However, the nature of some of this contact may have a negative effect and reinforce stereotypes of helplessness and dependence. Contact within OT is both structured and unstructured. Structured contact comes through lectures, seminars and video presentations where disabled people talk about what it is like to be disabled. This may have a positive effect by challenging stereotypes, legitimating curiosity and because these disabled people are of equal status to the students. However students will also be exposed to unstructured contact with disabled people who are also their patients and clients and, although there may be elements of co-operative interdependence within this contact, the effect of the inequalities of status between professional and client do not often have a positive effect on attitudes, beliefs and stereotypic notions of helplessness and dependence. This issue will be discussed further in the final section of this chapter.

Information, persuasion and discussion

Lectures, seminars and videos by disabled people appear to affect attitudes positively. It appears that it is the presence of the disabled person which is the critical factor. Donaldson (1980) reports on a number of studies which have used information about disabled people and presentations as methods of changing attitudes but to no effect. It is the disabled person who is seen as

the credible information source and where this is lacking and non-disabled people present information they are not perceived as a credible source and, therefore, attitudes do not change. Although there are disabled people on some of the module teams, the majority of the BSc in OT course at Oxford Brookes University is taught by non-disabled people. It may be that, although the course includes information about the experience of disability, the majority of the people who are giving that information are not perceived as credible sources of information. Yuker and Hurley (1987) argue that contact and information have an interaction effect and that contact without information is less effective than contact and information.

Group discussions were also highlighted by Donaldson (1980) as a possible technique for attitude change. However she cites a study by Siperstein, Bak and Gottlieb (1977) which yielded negative shifts in attitudes following a group discussion on the problems of disability. Group discussions may be counter-productive and serve only to allow people to voice their stereotypical opinions and thus reinforce negative attitudes.

Disability simulation

The final technique for changing attitudes is disability simulation. This is where non-disabled participants spend some time pretending to be disabled, by using a wheelchair for mobility, wearing opaque glasses to simulate visual impairment or putting cotton wool in their ears to simulate a hearing impairment. These techniques are highly contentious and research using simulations has yielded equivocal results (Donaldson, 1980; Kiger, 1992;

French, 1992c), although, as Kiger (1992) notes, qualitative results usually indicate the positive effects on participants.

Donaldson (1980) and Clore and Jeffery (1972) propose that the reason disability simulation might work in changing attitudes is because it allows non-disabled participants to develop an empathetic understanding of what it is like to be disabled. Not only do they experience the frustrations of architectural and environmental barriers, they also observe the reactions of non-disabled people and begin to grasp the social reality of disability at first hand.

Wright (1980) highlights the positive and negative effects of disability simulations. By focusing on the frustration of being visually or hearing impaired or a wheelchair user it is possible to reinforce the negative aspects of being disabled. Wright (1980) cites various negative responses; for visual impairment: loneliness, fear and helplessness; for hearing impairment: a tendency to withdraw, depression and fear of others talking to you; and for wheelchair users: dependence, irritation and embarrassment. Clore and Jeffery (1972: 110) also found that their

> subjects either directly or vicariously experienced feelings related to the anxiety, impotence, embarrassment and exhaustion that they would have felt if they had really been experiencing their first day confined to a wheelchair.

Thus only the negative aspects and problems of disability are reinforced and attitudes are not changed. However, if simulations focus on the 'coping

framework' (Wright, 1983) and the notion that living with a disability is neither hard nor easy, but 'that needs can be met when reasonable accommodations are made' (Wright, 1980: 276), positive images may be reinforced. Central to any simulation is discussion and feedback (Kiger, 1992) so that 'a constructive view of life with a disability' (Wright, 1980: 274) can be fostered.

French (1992c) has been highly critical of disability simulations, not only because of the limited evidence of their effectiveness in changing attitudes, but also because they do not simulate the experience of disability, but only serve to trivialise and individualise disability. Spending a day in a wheelchair might give some idea of the mobility problems a wheelchair user has, but can give no insight into the problems caused by lack of bowel or bladder control, poor or abnormal sensation or high or low muscle tone. As Clore and Jeffery (1972) pointed out, their respondents had some idea of what it was like to use a wheelchair for the first time, but most disabled people have had years of adaptation and refining their living skills. The major problems of disability, the oppression of poverty, unemployment and poor educational opportunities are totally ignored in simulation exercises. As Finkelstein (1991b: 5) points out

> ... disability has nothing to do with standing on one leg, using a wheelchair, or bumping around in the dark with one's eyes closed ... Disability is not a dilemma, it is about lifestyle, about discrimination and about ignorant able-bodied service-providers who inculcate narrow medical and paramedical stereotypes into the minds of the future generation.

By focusing on using a wheelchair, being blindfolded or putting cotton wool in one's ears, disability simulations are concentrating purely on the impairment, ignoring the disability and reinforcing the 'master status' or 'spread' of the impairment to make it the sole salient feature of the disabled person. The focus on the individual reinforces

> ... the medical model approach to disability and serves to reinforce the negative view that disability is only some terrible personal tragedy and cannot encompass the view of disability as part of a fulfilling or unfulfilling life experience (London Boroughs Disability Resource Team, 1991, cited in French, 1992c: 264).

Whilst Kiger (1992) has pointed out the ethical issues for participants in disability simulations, in terms of coercion to participate and unresolved feelings at the end of the exercise, no-one has highlighted the ethical dilemma of deceiving the general public. Anyone helping a participant in a disability simulation assumes they are helping a disabled person. One of the most frequent criticisms of disability simulations made by the researcher's students has been the ethics of deceiving and misleading people and the feelings of guilt that this exercise can produce.

A number of studies have attempted to investigate the effectiveness of disability simulations in changing attitudes towards disabled people. Wilson and Alcorn (1969) compared the ATDP scores of a control group of students with those of students who had spent a continuous 8-hour period simulating either blindness; deafness; loss of the dominant hand; or loss of lower limbs.

They found no significant differences between the two groups. Qualitative data revealed feelings of loneliness, frustration and helplessness. Semple, Vargo and Vargo (1980) used a 2-day disability simulation task with physical therapy students. They also found no difference in ATDP scores between the experimental and control groups. Chard (1997: 163) found that OT students, non-disabled members of the general public and disabled people saw disability simulations as the most effective way of 'learning how it feels to be a wheelchair user'. She also reported that when reflecting on spending time in a wheelchair her students

> used words such as dependent, vulnerable, embarrassed, empathy and insight to describe the value of their experiences (Chard, 1997: 165).

Thus empirical evidence would appear to support the criticisms of disability simulations.

At the time of the data collection for this study, disability simulation was included within one of the first year modules of the BSc in OT course (module 1504: The sociology of impairment, disability and handicap), although this has subsequently been changed.

Attitudes of health professionals towards disabled people

McDaniel (1976) has stated that the attitudes of the professionals who work with disable people are probably the most important factors in determining a person's response to treatment. This chapter will conclude with a review of the research into the attitudes of health professionals towards disabled

people and a continuation of the discussion of the factors that might be influential in changing those attitudes and the nature of empowering and oppressive attitudes. The attitudes of health professionals have been identified as so crucial that Yuker (1976) has proposed that people holding negative attitudes towards disabled people should be prevented from entering professions which involve interaction with disabled people. At the very least, Yuker (1976) argues, the educational process of these professions should attempt to address attitudes towards disabled people. For the profession of OT, Benham (1988) has echoed Yuker's comments and has proposed that prospective applicants to OT education should be screened for positive attitudes towards disabled people. Reed and Sanderson (1982) have noted that attitudes are the basis of the therapeutic relationship and, therefore, the treatment process. Yerxa (1980) has highlighted the importance of positive attitudes amongst OTs by arguing that OTs have an ethical responsibility to influence society and the medical profession in their perceptions of disability.

As was noted in the previous section, contact is the crucial variable when attempting to influence attitudes. This, however, is where the problem starts where health professionals are concerned. The nature of the contact between health professionals and disabled people is, by its very nature, unequal. The health professional is in a position of power relative to the disabled person. They are the holders of knowledge and are often the gatekeepers to services and resources. The health professional is there specifically to 'help' or 'care

for' the disabled person. It would, therefore, seem inevitable that the attitudes of the health professional would suffer,

> many physicians and other professionals (and volunteers as well), who work in rehabilitation, do not have positive attitudes towards their patients (Yuker & Block, 1979: 53).

This may not be seen as wholly surprising when the motivation to be in a 'caring' profession is to care for, look after, and do good to people, in other words to patronise or 'mother' them, This is in conflict with positive attitudes, which, as we have seen, are focused on equality and civil rights.

In an extensive review of the literature in this area, Chubon (1982) found that there was little clear evidence to suggest that professionals had less positive attitudes than any one else, nor to clearly link treatment outcome and attitudes. In fact, Chubon (1982) proposed that negative treatment outcomes might have a negative effect on attitudes and not the other way around. His main conclusion, however, was that the majority of the research had a limited theoretical base and numerous methodological flaws which limited the usefulness of the results of the research. One of his conclusions has clear implications for the current study; that

> these findings indicate a need to conduct longitudinal studies beginning at the outset of professional training and extending several years into the work life of professionals to determine if, when, and in whom changes occur (Chubon, 1982: 28).

This finding was one of the key reasons for the choice of a longitudinal case study design for the current research.

To provide a background to this study, recent research into the attitudes of health professionals towards disabled people has been reviewed. Because of the utilisation of the ATDP within this study the majority of research papers reviewed have used the ATDP in one of its three forms. The findings of these studies are summarised in Table 4:1 below. Other studies using measures other than the ATDP were also looked at and these studies and their findings are summarised in Table 4:2 below.

Table 4:1: Overview of research with health professionals (excluding OTs) using the ATDP

[the norm scores for the various ATDP forms are: ATDP/O: 79.7; ATDP/A: 117.1; & ATDP/B: 116.9 (Yuker & Block, 1986)]

Author	*Respondent Groups*	*ATDP Forms O, A or B*	*Findings*	*means*
Huitt & Elston, 1991	comparison of attitudes between 3 groups of counsellors: school, rehabilitation & mental health (MH), n= 86	A	no significant differences, but all groups more positive when compared to norm	rehab - 131.59 school - 128.08 MH - 131.5
Vargo & Semple, 1988	comparison of professional & personal attitudes amongst physiotherapy students, n= 40	A	professional attitudes were significantly more positive than personal attitudes	prof - 114.3 pers - 108.35
Paris, 1993	comparison of 1st & 4th year medical students and health professionals, n=297	B	1st year students were significantly less positive than either 4th year students or health professionals, women more positive than men; no significant correlation between ATDP and age, no significant effect of contact (professional/social, or frequent/infrequent)	overall - 123 range: 47 - 169 med1 - 119.78 med4 - 127.16 health - 125.16
Whitby, 1986	comparison of student nurses before patient contact (1st years) and at the end of training, n=47	O	no significant differences	no means given

Lindgren & Oermann, 1993	examination of the effect of a one day course on disability on nursing students, other variables: age, gender, stage of training, type of training & previous experience, n=263	O	attitudes were significantly more positive after the course; no correlation of age and pre-test score but weak negative correlation of age and post-test score; no difference on gender, stage of training or type of training; pre-test those with previous experience with disabled people were more positive but this was not present post-test	pre - 81.6 post - 88.4 exp - 86.6 noexp - 82
Laking, 1988	comparison of medical students before and after a short course on disability, also health professionals group, n=46 (students) n=45 (professionals)	O	no significant difference in medical students pre & post test, or on gender or contact; significant difference on gender in professional group, females more positive than males, no other significant differences in this group; students and professionals were not compared; medical students do not seem more positive than the general population	students - 64.9 profs - 79.5
Murray & Chambers, 1991	the effects of placements (district or mental handicap settings) on students nurses' attitudes towards elderly people, disabled people and people with a mental handicap n=24	O	before placement attitudes towards elderly people were more positive than towards disabled people or people with a mental handicap; after placement attitudes towards disable people had become more positive, attitudes towards elderly people or people with a mental handicap had remained the same or become more negative	no means given
Elston & Snow, 1986	comparison of rehabilitation counsellors, sheltered workshop and rehabilitation centre staff, n=235	A	no significant difference between groups, scores fell within the normal range	no means given
Duckworth, 1988	comparisons of 1st year medical students, 4th year students, SHOs and the general public, n=263	A or B *unclear in text*	no significant difference between groups, nor on age gender or contact	gen pop - 120.7 SHOs - 123.6 med1 - 125.6 med4 - 121.4
Daniels, 1978	exploration of correlation of attitudes towards disabled people, sexuality & the sexual behaviour of disabled people amongst health professionals, n=53	O	attitudes towards the sexual behaviour of disabled people are associated more with attitudes to sex than attitudes towards disabled people	no means given
Bell, 1962	comparison of rehabilitation workers(a), hospital staff with no patient contact(b), hospital staff with no patient contact but with personal contact with disabled people(c) n=110	O	hospital staff with no patient contact but with personal contact were significantly more positive than the other 2 groups	a - 75.8 b - 76.4 c - 87.1
Speakman & Kung, 1982	establishing descriptive and normative data on physical therapists' attitudes n=125	A	range of scores and distribution described: 70-165, with median of 124.5, to establish possible screening tool for applicants to physical therapy training courses	median score - 124.5

Brillhart, 1990	comparison of nurses' attitudes at the beginning and end of training with practitioners, faculty and disabled people, n=374	O	significant differences between groups; disabled people the most positive, then registered nurses, beginning students, graduating students, with faculty the least positive	begSN - 46.09 gradSN - 41.56 RN - 46.71 fac - 38.06 dis - 84.09
Onuoha, 1992	comparison of 'honest' and 'faked' attitudes in foundation course physiotherapy students n=34	A	significant difference between 'honest' and 'faked' responses, with 'faked' responses being more positive	'honest' – 110.24 'fake' – 122.91
Bohlander, 1985	comparison of physiotherapists' and school teachers' attitudes n=62	A	significant differences, with physiotherapists the more positive	median scores: physio - 132 teach - 108

summary of findings:

Of the 15 studies summarised, 6 looked at the differences in attitudes between health professionals and other people and one looked at differences between groups of health professionals, 7 looked at the effects of education on attitudes, one compared personal and professional attitudes, one looked at whether attitudes towards disabled people correlated with other attitudes, one attempted to establish norms for a professional group and one attempted to assess the suitability of the ATDP as a screening tool for applicants to physiotherapy courses.

Looking at professional attitudes, only 3 studies (Vargo & Semple, 1988; Bohlander, 1985; Brillhart, 1990) found significant differences between professional attitudes and others, although it must be noted that Brillhart (1990) found disabled people to be significantly more positive in their attitudes than nurses, with faculty the least positive. There does not, therefore on this evidence, seem to be a case for saying that health professionals are more positive in their attitudes towards disabled people than the general public. Bell (1962) found that rehabilitation workers were significantly less positive than other health workers who had personal contact with disabled people

The results of studies into the effects of education appear equivocal, with 2 studies (Paris, 1993, Lindgren & Oremann, 1993) finding education having a positive effect, 3 studies (Whitby, 1986, Laking, 1988, Duckworth, 1988) finding that education appears to have no effect on attitudes, Murray & Chambers (1991) finding that placement had a negative effect on attitudes towards elderly people and people with a mental handicap but a positive effect on attitudes towards disabled people, and Brillhart (1990) finding a mixed result with practice appearing to have more effect than education.

The somewhat equivocal findings of these studies indicate the complexity of professional attitudes. It might be that the ATDP could help researchers to identify respondents who have a particular notion of what a 'positive' attitude might be, rather than to make true comparisons between groups of respondents.

Speakman and Kung (1982) proposed the use of the ATDP as a screening tool to be used as part of the selection procedure for physical therapy

students. However other researchers (Novick, 1972, 1982, Vargo & Semple, 1984, cited in Yuker, 1986) have argued strongly against this on the grounds that the ATDP might be susceptible to faking and the production of falsely positive scores. Yuker (1986: 203) reviews the research for and against faking in the ATDP and concludes that, whilst faking might be possible, the production of a highly positive score indicates an understanding of what a positive attitude should be and, therefore, might be indicative of someone who

> might turn out to be effective rehabilitation personnel because they seem to be aware of what constitutes "positive attitudes".

This is borne out by Onuoha's (1992) attempt to use the ATDP as a screening tool for potential physiotherapy students, as Speakman and Kung (1982) recommended. Onuoha concluded that whilst the ATDP might not be a reliable screening tool, it was a suitable measure of positive attitudes towards disabled people.

Table 4:2: Overview of research with health professionals (excluding OTs) using measures other than the ATDP

Author	*Respondent Groups*	*Measures Used*	*Findings*
Weller & Grunes, 1988	examining the effects of contact (high, medium, none) on nurses' attitudes towards psychiatric patients, n=95	Attitudes towards Mental Illness questionnaire	contact had no effect on attitudes, there were no differences between groups; practical nurses were more positive than registered (more management oriented) nurses; more religious nurses were more positive than secular nurses
Gething, 1992	exploring identity 'spread' and implicit personality theories about disabled people amongst trainee and practising health professionals, looking at the effects of disability, gender and behaviour on perceptions of an individual, n=636	semantic differential stimulus presentation by video: gender, disability (use of a wheelchair) and behaviour (shy, neutral, brash)	3 factors emerged: social adjustment, coping/succumbing & psychological adjustment; differences for each variable (disability, gender, behaviour) were significant for each factor, and for the interaction between gender and disability and gender and manner; whilst disability has a negative effect on impressions it cannot be isolated from other factors
Tolor & Geller, 1987	exploration of psychologists' attitudes towards various disabling conditions in children, n=61	semantic differential, social distance and Adoption scales	children with problems categorised as 'organic and sensorimotor' were seen in a more positive light (on all scales) in comparison to children with problems categorised as 'functional and psycho-educational'
Beckwith & Matthews, 1995	Comparison of clinical psychology students' attitudes over 3-year training course n=75(1st year students) n=15(3rd year students)	Scale of Attitudes toward Disabled Persons (Antonak, 1981), intellectual Disability Misconceptions Scale	No significant differences between 1st and 3rd year student, the authors also concluded that neither scale was a useful measure for tracking attitudes throughout the process of professional socialisation
St Claire, 1986	comparison of lay people's and psychologists' beliefs about people with mental handicaps, n=395(lay people) n=52(psychologists)	semantic differential	lay people with contact had more positive attitudes than lay people with no contact; psychologists with contact were positive but on fewer scales than lay people; lay people and psychologists were not compared; overall psychologists evaluated people with a mental handicap more negatively

St Claire (1986) highlights the negative effects of professional contact with disabled people. She proposes that the more negative attitudes that she found amongst psychologists were not due to personal beliefs but rather to the ideology and philosophy of clinical psychology as a profession.

> This is not taken to mean that the psychologists were unsympathetic, or that contact had failed to bring them personal enlightenment. Rather, their beliefs are taken to reflect the negative evaluations intrinsic to the statistical and medical perspectives that are relevant to psychologists as opposed to lay people ... for psychologists 'dependent', 'unable to cope' and 'helpless' together with 'understood' seem reflections of a professional norm that retardates are patients, not people (St Claire, 1986: 240-241).

The effect of professional ideologies has been clearly illustrated by Scott (1974) in his overview of perceptions of blindness. He argues that, not only are there professional ideologies but that they vary from country to country. The prevalent idea in North America is on personality and psychological adjustment, whilst in Sweden blindness is seen as a technical handicap to be 'compensated by the mastery of new techniques and by the use of technical aids' (Scott, 1974: 110), and in England people with visual handicaps are 'constantly in danger of becoming depressed and filled with despair about their plight' (Scott, 1974: 111).

The notion of disabled people as patients and, therefore, inherently 'different' has been highlighted in Speakman's (1989) attempt to devise a New Scale

for the measurement of attitudes. One of his main criticisms of the ATDP was the assumption that disabled people were no different from non-disabled people. This would cause 'enlightened' professionals, in Speakman's case physiotherapists, to record more negative attitudes because they are only too aware of disabled people's differentness. This might also lead to the professional attitudes, which acknowledge differentness, being more negative than the personal attitudes held by the same health professionals. This, however, has not been the case. Vargo and Semple (1988: 24), in an attempt to reconcile the apparent confusion over whether attitudes of health professionals were positive, negative or no different from those of lay people, proposed that perhaps

> attitudes of rehabilitation professionals are influenced by which 'hat' they are wearing at any given time. Do they distinguish between their professional and personal attitudes?

They asked physiotherapy students to complete the ATDP twice, once with the instruction

> respond to this questionnaire according to your *professional* reaction to each of the items

and once with the instruction

> respond to this questionnaire according to your *personal* reaction to each of the items.

Interestingly, they did not predict whether professional attitudes would be more positive or negative than personal attitudes. They found that the professional attitudes were significantly more positive than the personal attitudes. This finding is interesting, and possibly worrying, for two reasons.

The difference between personal and professional attitudes appears to indicate that professionals 'put on' their professional, and positive, attitudes with their uniforms or work, that they are not naturally caring people. However, this inconsistency of attitude is worrying as it might not lead to consistent professional behaviour and might lead to stress within the work situation due to the cognitive dissonance of professional and personal attitudes. The second point of interest, that if personal attitudes are no different from those of lay people, this calls into question Benham's (1988) proposal for screening prospective candidates to OT. It might be that these findings are true only for physiotherapists or that they are incorrect or an artefact. It might highlight a methodological issue that previous attitude research has not clearly focused on professional *or* personal attitudes and has, therefore, produced results which are a conflation of the two. The notion of comparison of professional and personal attitudes has been explored further within the current research.

Disabled people as health professionals

One area where the conflict and confusion of personal and professional attitudes might be clearly seen is in the experience of disabled people who are also health professionals. Here are a group of people who have crossed the divide between patient and person, and as a result may cause other health professionals some discomfort and confusion as to how to deal with them. Kerr (1970) has described her experience as a health professional with a disability. She found that the presence of her wheelchair influenced the expectations and behaviours of colleagues and other staff. She describes, for

example, an incident where she used the main entrance of a hospital where she was not known, to visit a client. She was greeted with terse comments that she had used the wrong entrance for the rehabilitation unit, her protests were ignored and a member of staff propelled her to the unit.

French (1988), in her series of semi-structured interviews with disabled professionals, found that the majority of professionals interviewed had received positive treatment from colleagues. A sizeable minority, however, had experienced some degree of negative discrimination either as a result of their colleagues' attitudes or lack of understanding. O'Hare and Thomson (1991) examined the working situation of physiotherapists who acquire a physical disability after entering professional education or starting work. Although their respondents did not perceive their disabilities to have affected their relationships with colleagues, only three of their 23 respondents agreed with the statement 'The physiotherapy profession welcomes physically disabled physiotherapists'.

The fact that the health professions do not 'welcome' disabled people was highlighted by French (1988). The majority of negative experiences reported in her study were linked with either accessing professional education or with the process of professional education. French (1986) found numerous examples of recruitment literature for the health professions where people with a range of disabilities were deemed to be unsuitable for training.

> Any form of physical disability or weakness is likely to contra-indicate physiotherapy as a suitable career, in particular defects in hearing,

> epilepsy, chest ailments, skin conditions, heart defects, nervous breakdown. Injuries to back, knees and hands may also prejudice acceptance for training (*How to become a physiotherapist*, 1984: 2, cited in French, 1988: 173).

French (1987) explored physiotherapists' attitudes towards the recruitment of disabled people into the physiotherapy profession. She found that a number of disabling conditions were seen as unsuitable for physiotherapy training, these included obesity, wheelchair user, severe asthma, schizophrenia, being deaf, physically inactive, and above-knee amputation. Disabling conditions considered suitable for physiotherapy training included controlled diabetes, partially sighted, blind, below-knee amputation, anxiety, and depression. Physiotherapy is often thought of as the sister profession to OT, but would appear to be less welcoming to disabled people than OT. Craik (1990: 14), in an article which can only be seen as actively encouraging disabled people into the profession, states

> OT has a commendable record in enabling people with disabilities to achieve their potential and join the profession and many more are establishing their careers,

although in real terms the numbers appear to be small. Elliott, Hanzlik and Gliner (1992) report on an American OT Association survey, which revealed that 4% of OTs and 6% of OT assistants had some type of disability.

Whilst the OT approach is commendable, Chinnery (1991) argues that it is only 'window-dressing' and that there is no real commitment to non-discriminatory, non-oppressive practice within the health care professions.

The skills and knowledge that disabled people have about disability is, at best, ignored and, at worst, devalued. Are OT students guilty of this oppression or are they more enlightened than their physiotherapy colleagues?

Attitudes of OTs towards disabled people

A small amount of research into OTs' attitudes towards disabled people has been published. As in the previous section, the research has been divided into studies using the ATDP and other studies and the findings of which are summarised in Tables 4:3 and 4:4 below.

Table 4:3: Overview of research with OT students using the ATDP

Author	*Respondent Groups*	*ATDP O, A or B*	*Findings*	*means*
Westbrook & Adamson, 1989	OT students, comparing knowledge and attitudes, between 1st, 2nd & 3rd year students, n= 233	O	knowledge was poor but increased with seniority, ATDP became more positive with seniority, no correlation between ATDP and knowledge	1st years - 78.9 2nd years - 83.7 3rd years - 91.9
Lyons, 1990	OT students and non-OT students (business studies), attitudes and contact (valued/other), between 1st, 2nd, 3rd & 4th year students, n= 223(OT), 326(non-OT), the proportion of males to females was higher in the non-OT group	A	no difference between OT and non-OT students, no difference between OT students by year, significant difference between students on contact variable	no means given
Lee, Paterson & Chan, 1994	OT students, comparing 2nd, 3rd and 4th year students with retrospective pre-test and post-test n=144	A	no difference between level of education results (post-test) but significant differences between retrospective pre-test (i.e. before training) and post-test scores	pre-test: 2nd years - 122.8 3rd years - 107.6 4th years - 105.7 post test: 2nd years - 131.8 3rd years - 137.3 4th years - 136.2
Kirchman, 1987	OT students in their Junior year were compared before and after a module on disability, n= 81	O	significant difference between students before and after the module	median scores: pre - 83 post - 89
Estes et al., 1991	OT students and medical technology students, 1st semester & 4th semester, n= 52 (13 in each group)	A	OT students more positive than non-OT students, 4th semester OT students more positive than 1st semester OT students, no difference between 1st & 4th semester non-OT students	OT1 - 119.3 OT4 - 136.6 tech1 - 118.2 tech4 - 113.2

Summary of findings:

Three, of the five, studies found that students became more positive in their attitudes towards disabled people as their courses progressed; one study (Lyons, 1990) found that there was no difference between students at the beginning and at the end of their course; Lee et al. (1994) found differences in pre-professional education and during education scores.

Of the two studies which compare OT and non-OT students, one (Estes et al., 1991) found that OTs were significantly more positive in their attitudes and the other study (Lyons, 1990) found that there was no difference between OT and non-OT students attitudes towards disabled people.

Table 4:4: Overview of research with OTs using measures other than the ATDP

Author	*Respondent Groups*	*Measures Used*	*Findings*
Todd, Rider & Page-Robin, 1987	investigation into the attitudes & level of knowledge of OT students towards the elderly, n=162 (undergraduate & graduate students)	Kogan Attitudes Towards Older Persons scale, & Palmore Facts on Ageing Quiz	students had positive attitudes towards the elderly; there was a positive correlation between attitudes & knowledge; the most significant positive factor was found to be a previous close relationship with an older person
Lyons & Hayes, 1993	examined the attitudes of OT & non-OT (business studies) students to persons with a variety of disabilities, stage of OT training was also compared, n=223(OT), n=326(business)	Disability Social Distance scale (Tringo, 1970)	1st year OT students expressed a desire for much less social distance, & therefore more positive attitudes, than 1st year business students; there was no significant difference between the OT students on stage of training; most acceptable conditions: asthma, diabetes, arthritis, ulcers, amputation & heart disease; least acceptable conditions: criminal record, alcoholism, mental illness, mental retardation, cerebral palsy & hunchback
Llewellyn, 1991	explored the focus and perspectives of OT practitioners on people with intellectual disabilities, n=21	focus group discussions	therapists act as advocates for their clients, particularly on independence issues; focus on enhancing quality of life by active participation; therefore, positive attitudes towards this client group
Eberhardt & Mayberry, 1995	explored attitudes of newly qualified OTs equal status contact and attitudes towards disabled people n=172	adapted Disability Social Distance Scale (Tringo 1970)	positive attitudes on DSDS, no significant correlation between DSDS score an levels of personal or professional contact; OTs working with patients with biomechanical or neurological impairments were significantly less positive than OTs working with non-disabled clients in 'wellness' settings
Benham, 1988	exploration of attitudes amongst OTs, n=619	Scale of Attitudes Towards Disabled Persons (SADP) (Antonak, 1982); Downs' syndrome scenario involving an ethical dilemma; statements about beliefs about the value of positive attitudes	on SADP respondents had very positive attitudes; OTs with 16+ years of practice had more positive attitudes than those with 6 - 10 years practice; beliefs about the importance of positive attitudes were highly correlated with SADP scores
Fleming, Gilbert, McKenna & Heath, 1997	Survey of 1st year OT students, explore attitudes towards disabled people as part of a wider survey of students' views, n=83	10 item subsection of questionnaire, designed for this study	students' attitudes were generally seen as positive, however responses to items on the amount of control a client had over treatment and the influence of cost on treatment were more equivocal

Elliott, Hanzlik & Gliner, 1992	study of OTs' attitudes towards hypothetical disabled OT colleagues n=204	Familiarity with Disability scale, social distance scales	attitudes towards working with OTs who were disabled were positive; responses to OTs with drug and mental health problems were somewhat negative; only 36% of respondents reported having worked with a disabled OT

The general flavour of the research into OTs' attitudes towards disabled people is that OTs do have more positive attitudes towards disabled people, although this is somewhat at variance with the research into the attitudes of health professionals generally, which tends to suggest no significant differences in attitudes, and the theoretical notions, which suggest that the nature of the professional/therapist relationship must reinforce negative attitudes. The case for the positive effect of education appears somewhat stronger with the majority of studies (Estes et al., 1991; Kirchman, 1987; Westbrook & Adamson, 1989; Todd, Rider & Page-Robin, 1987) demonstrating a correlation between stage of training or knowledge and attitudes towards disabled people.

Can attitude questionnaires identify and measure empowering and oppressive attitudes?

Earlier in this chapter the nature of positive attitudes towards disabled people was explored. The previous chapters have attempted to explore and articulate issues of oppression and empowerment in relation to disabled people. It is now time to draw these themes together and to discuss how attitude measurement can be used as a way of operationalising and assessing empowering and oppressive attitudes towards disabled people.

The first task is to discuss the relationship between positive and empowering attitudes, and negative and oppressive attitudes. The second task is to discuss how the measures chosen for this study can be used to assess empowerment and oppression. The final task is to outline what an empowering or oppressive attitude might be, using the tools chosen for this study.

Using the findings of the various studies discussed in this chapter, and especially the work of Makas (1988), it is possible to outline what constitutes positive and negative attitudes towards disabled people. This is done in Figure 4:1, below, by highlighting key words pertinent to each attitude.

Figure 4:1: Comparison of positive and negative attitudes towards disabled people

negative attitudes	*positive attitudes*
fear/discomfort	same as anyone else
negative emotions	equal status
different	seen as equals
segregation	focus on the person
tragedy/victim	focus on abilities
weak/helpless/needy	accepting
dependent	do not avoid contact
sad	competent
isolated	neutral or positive emotions
unstable	defend civil and social rights
low status	
focus on limitations/disability	
avoid contact	
patronise	

Drawing on the research discussed in chapter 2, it is also possible to outline empowering and oppressive attitudes in the same way, as Figure 4:2 shows.

Figure 4:2: Comparison of empowering and oppressive attitudes towards disabled people

oppressive attitudes	*empowering attitudes*
powerless	equality
useless	equity
dependent	disabled person in control
in need of care/help	choice
needing to change	facilitate to achieve goals
victims	civil rights
controlled by others	rights not charity
limited choice	respect
focus on difference	acknowledge differences
personal tragedy	full member of society
focus on limitations	
discrimination	
courageous	
treat differently	

It can be seen that there is a considerable degree of overlap between negative and oppressive attitudes and between positive and empowering attitudes. It would, therefore, be safe to conclude that assessing positive attitudes towards disabled people is a useful method of operationalising empowering and oppressive attitudes towards disabled people.

The measures chosen to assess attitudes towards disabled people in this study are:

the Attitudes Towards Disabled People Scale (ATDP);

the Disability Social Distance Scale (DSDS);

a Suitability for OT Scale;

a Disability Semantic Differential Scale;

a Social Distance Scale.

Whilst these measures will be discussed in detail in the following chapter, it seems appropriate to review the ability of these measures to assess empowering and oppressive attitudes here.

The ATDP specifically aims to measure positive attitudes towards disabled people. The ATP defines a positive attitude as seeing disabled people as no different from anyone else. The items on the ATDP can be divided into two groups. One group of items looks at the ways disabled people are 'treated', e.g.

It would be best for physically disabled people to live and work in special communities.

The other group of items looks at 'characteristics' of disabled people, e.g.

Physically disabled people are more easily upset than other people.

For both sets of items a positive attitude is that disabled people should be viewed (or treated) no differently from non-disabled people. However, Yuker and Block (1986: 31) argue that the correlation between these scales indicates that

the two types of items are not independent and may be considered to contribute approximately equally to the total scores

and, therefore, propose that the ATDP should not be divided into sub-scales. Other researchers (e.g. Antonak, 1980; Furnham & Pendred, 1983; Livneh,

1982) have analysed each item separately and using factor analysis, with varying results. Factor analysis of the data from this study will be compared with the results from these studies. It also seems appropriate to explore the 'characteristic' and 'treatment' sub-scales in an attempt to clarify empowering and oppressive attitudes. The 'treatment' sub-scale, particularly, will be important in determining whether respondents' attitudes are empowering or oppressive, as the central focus of these items is whether disabled people should be treated equally and no differently from non-disabled people. It would, therefore, seem that the ATDP, for all its recognised flaws and limitations, is a suitable tool for the task of exploring not only positive attitudes towards disabled people but also empowering attitudes.

Tringo's (1970) Disability Social Distance Scale forms a relatively small part of the research tool, having been used with a small group of OT students as the data collection process drew to a close. It was used to explore whether, in spite of holding positive and empowering attitudes, OT students had a hierarchy of preference for people with different impairments and disabling conditions. Of particular interest was whether OT students hold less positive attitudes, in terms of greater preferred social distance, from people who might be perceived as most stigmatised by society in general, i.e. people with mental health problems. Whilst these data cannot be specifically related to empowering or oppressive attitudes, except in general terms of avoiding contact, it does serve to deepen our understanding of the nature of attitudes towards people with disabilities amongst OT students, and might highlight avenues for further study.

A central aspect of empowerment is that disabled people should be treated equally and given the same opportunities as non-disabled people. The Suitability for OT Scale seeks to explore how far this aspect of empowerment is seen in terms of equality of opportunity to train to become an OT. We have already discussed whether OT is a profession which welcomes disabled students. This Scale will measure how oppressive or empowering respondents are in terms of their willingness see disabled people, irrespective of the nature of their disability, as having the potential to become OTs. Responding that someone who uses a wheelchair, for example, is not suitable to train as an OT can be seen as oppressive as an opportunity, open to non-disabled people is being denied. The assumption would appear to be that the professional practice of OT could not be changed or adapted to enable the disabled person to train or practice.

The Disability Semantic Differential Scale is being used not only to explore images and stereotypes of disabled people, but also to explore whether particular aspects of that image are empowering or oppressive. Thus the Scale includes bi-polar constructs which highlight oppressive or empowering attitudes, e.g.:

helpless – competent

dependent – independent

valuable – worthless

an asset to society – a burden on society

employable – unemployable.

The final Social Distance Scale attempts to capture the behavioural component of attitudes towards disabled people. In other words, whether respondents felt sufficiently positive about disabled people to be prepared to contemplate forming social relationships with them. As with the DSDS, this measure does not address oppression and empowerment directly, but serves to deepen our understanding of the nature of positive attitudes towards disabled people.

The measures used in this study which operationalise oppressive and empowering attitudes directly are:

the ATDP

the Suitability for OT Scale

the Disability Semantic Differential Scale.

High scores on the ATDP, and particularly on the 'treatment' sub-sale, can be seen as indicating not only positive but empowering attitudes towards disabled people. High scores on the Suitability for OT Scale will also indicate empowering attitudes, as the respondent perceives all disabled people to be potentially suitable to study OT. Specific items on the Disability Semantic Differential Scale will indicate whether respondents hold patronising and oppressive views of disabled people, e.g. dependent, a burden on society, worthless, unemployable.

Conclusion

The literature on the nature and measurement of attitudes towards disabled people, with particular reference to the attitudes of health professionals and

OTs in particular, has been reviewed. Whether the attitudes of OTs towards disabled people are more positive than those held by non-OTs remains in doubt. The role of contact with disabled people as equals with valued social roles has been emphasised as a key variable in the development of positive attitudes towards disabled people. However, the effect of professional education and socialisation upon the attitudes of OT students towards disabled people appears mixed. There is no clear consensus of their effectiveness either in making attitudes more positive or in facilitating students' understanding and application of theoretical concepts and values. This study hopes to add to the existing body of knowledge and research and to clarify the picture. The aims of this study are not only to explore the attitudes towards disabled people of OT students, but also, by utilising a longitudinal case study design, to see whether these attitudes change and what aspects of the professional socialisation process are the most influential in any change; to see whether personal and professional attitudes differ; to see how these attitudes compare with those of the faculty role models and those of non-OT students; and to see how well students can articulate and apply the principles of the social model of disability in terms of their own practice.

Chapter 5

METHODOLOGY

The aims of this study were to explore the attitudes towards disabled people held by occupational therapy students and to find out whether these attitudes changed during the three year degree programme, which makes up the initial stage of these students' professional socialisation as occupational therapists, and whether these attitudes were compatible with the social model of disability. This was done by means of a longitudinal case study following a cohort of students through their degree studies and collecting data at various stages during this programme. In order to establish what a 'professional' attitude is, it was considered necessary to collect data on 'non-professional' attitudes and so data were also collected from groups of non-OT undergraduate students.

This chapter will discuss the merits of both qualitative and quantitative research methodologies and explain why an integrated methodology was chosen. It will then go on to explore the various approaches within qualitative and integrated research and justify the chosen approach, a case study. The nature of the population and sample will be outlined. The development of the data collection methods and tools will be discussed and the chapter will conclude with an overview of the procedure.

Qualitative, quantitative or integrated methodology?

The choice of research methodology and methods depends not just upon the nature of the topic and the research question, but also upon the philosophy of the researcher (Polit & Hungler, 1995, Streubert, 1995, Robson, 1993). As far as this topic is concerned it has been noted, in the preceding chapter discussing research into attitudes towards disabled people, that the majority of research has come from a quantitative methodological background, where questionnaires and surveys have been used to measure attitudes and test hypotheses concerning the attitudes of various respondent groups. However, it was also noted, in support of researchers such as Laking (1988), that these quantitative tools might not be subtle enough to record changes in attitudes over time. This, however, does not seem sufficient argument to condemn quantitative methodology as an inappropriate choice of methodology for this study. We must, first, carefully consider the relative merits of quantitative and qualitative methodologies and then discuss, what DePoy and Gitlin (1994) refer to as, integrated research designs.

Quantitative methodology

> Quantitative research involves the systematic collection of numerical information, often under conditions of considerable control, and the analysis of that information using statistical procedures (Polit & Hungler, 1995: 15).

Quantitative research aims to test hypotheses and make predictions about cause and effect. Quantitative research uses deductive reasoning to test

theories and has its roots in logical positivism. The focus of quantitative research is usually on a single dimension, with the researcher controlling and manipulating the independent variable and measuring the resultant change in the dependent variable.

This study is not aiming to test a single hypothesis, nor to manipulate one variable. It is aiming to explore a research question to develop a better understanding of the issue of professional attitudes and to begin to explore a variety of variables which might influence the development of these professional attitudes. A quantitative *methodology* would not, therefore, appear to be the appropriate choice for this research. However, quantitative *methods* of data collection might be appropriate within an integrated methodological framework.

Previous research on attitudes towards disabled people has attempted to measure attitudes and to establish whether groups of subjects are more or less positive in their attitudes. However, much of the research which has attempted to demonstrate a change in attitudes over time, or education, has produced equivocal results (e.g. Whitby, 1986; Laking, 1988; Duckworth, 1988; Lyons, 1990; Lyons & Hayes, 1993; Lee et al., 1994), although qualitative and anecdotal evidence might indicate that attitudes have changed. It might, therefore, be concluded that whilst attitudes do change, the existing quantitative measures are not sufficiently sensitive and sophisticated to measure them. Equally, as previous discussions have

indicated, a positive attitude is highly complex and whilst an attitude scale gives a numerical value it does not highlight subtle variations in aspects of an attitude which might change over time.

Quantitative methods do, however, allow the comparison of data from a number of groups and so, within this study, would allow a global picture of OT students' attitudes towards disabled people to emerge. Thus, aspects of this study will involve the collection of quantitative data. The depth of information will come from qualitative methods of data collection.

Qualitative methodology

Qualitative research involves the systematic collection and analysis of more subjective narrative materials, using procedures in which there tends to be a minimum of researcher-imposed control (Polit & Hungler, 1995: 15).

Qualitative research is inductive rather than deductive; it seeks to discover and explore subjective realities rather than to test theories in an objective world. Qualitative research aims to discover the 'insider perspective', the participants' point of view and their subjective perception of the phenomenon being studied (Streubert, 1995). The researcher may use a variety of methods of data collection (Denzin & Lincoln, 1994). Indeed

> the researcher is committed to the discovery of information. Methods and data collection strategies may change as needed, rather than being prescribed before the inquiry begins (Streubert, 1995: 10).

The use of multiple methods is aimed at giving breadth and depth to the topic being studied and also to triangulate the study. Denzin and Lincoln (1994) argue that triangulation is more than a strategy for validating the research, it is 'an alternative to validation' (Denzin & Lincoln, 1994: 2).

Denzin and Lincoln (1994) point out that qualitative research can include instrumentation, quantification and statistical measures

> to extend and reinforce certain kinds of data, interpretations and test hypotheses across samples ... Many qualitative researchers in the post-positivist tradition use statistical measures ... they seldom report their findings in terms of the kinds of complex statistical measures or methods to which quantitative researchers are drawn (e.g. path, regression or log-linear analyses) (Denzin & Lincoln, 1994: 5).

Qualitative research fits very closely with occupational therapy's view of the world. OTs seek to understand their patients' realities and to work with them in their subjective worlds. Their values are those of the qualitative rather than quantitative researcher (Yerxa, 1983). Qualitative research also fits very closely with the researcher's own philosophy and way of thinking.

Qualitative methodology would, therefore, seem to fit closely with the questions to be asked in this research. The research is aiming to explore and understand professional attitudes towards disabled people. This can only be done by exploring with the respondents (OT students) what their ideas and

realities are and to do this by means of a variety of methods which can evolve as the study and the researcher's understanding expands and develops. Although, as we have seen, attitudes are frequently measured. It would, therefore, appear that both quantitative and qualitative methodologies have a place in this study. An integrated approach would appear to be the most appropriate design to address all of the questions within this study.

Integrated research designs

> The intent of integration is to strengthen a study by selecting and combining designs and methods from both paradigms so that one complements the other to benefit or contribute to an understanding of the whole. ... the combination of different perspectives to examine the same phenomenon has the potential of producing a more holistic and comprehensive understanding that the use of singular strategies (DePoy & Gitlin, 1994: 147-8).

DePoy and Gitlin (1994) propose a continuum of integration from triangulation at the most basic level, through mixed methods approaches to full integration. In a fully integrated design both qualitative and quantitative paradigms are involved, but neither takes precedence over the other. Both research paradigms contribute to the study and complement each other in developing a deeper understanding of the phenomenon being investigated.

The research question, data collection and data analysis all must allow for the complementary use of both qualitative and quantitative research

methodologies. The research problem and research questions in this study are complex and warrant an integrated approach. Whilst attitudes can be measured, the effects of those attitudes on practice can only be explored through more qualitative methods. Whilst data collection and analysis have tended to be in parallel, rather than truly integrated, the final conclusions will draw the data together within an integrated overview.

Perhaps the strongest argument for the use of an integrated design in this study is DePoy and Gitlin's (1994) identification of the case study approach as one of the two integrated design strategies. The other strategy being focus group research.

Using a case study approach

As this study aimed to draw together both qualitative and quantitative methods and data within an integrated methodological framework, it seemed that a case study approach was the most appropriate. Robson (1993: 5) defines case study research as

> a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence.

According to DePoy and Gitlin (1994), a case study design is the ideal method for studying a complex phenomenon over time and in its own context. The interplay of professional socialisation and professional attitudes is highly

complex, and, therefore, this study would appear to fit DePoy and Gitlin's criteria for using a case study design.

Stake (1994) identifies three types of case study: intrinsic case study; instrumental case study; and collective case study. He defines an instrumental case study as one where ' a particular case is examined to provide insight into an issue or refinement of theory' (1994: 237). He cites Becker et al's (1961) study of medical students as an example of an instrumental case study. In the same way as Becker et al were exploring the professional socialisation of medical students, this study is exploring aspects of the professional socialisation of OT students, and so might be defined, in Stake's terms, as an instrumental case study.

Robson (1993), drawing on Hakim's (1987) work, identifies five types of case study, one of which is 'studies of events, roles and relationships' (Robson, 1993: 147). This study is exploring professional roles and relationships, which thus reinforces the choice of a case study approach for this research. Robson goes on to highlight the importance of the research questions within the case study.

The research questions for this study can be defined as follows:

> what, amongst OT students, is a 'professional' attitude towards disabled people?

are the attitudes of OT students towards disabled people any different from those of other students?

do these attitudes change over time?

are there any differences in the 'personal' and 'professional' attitudes of OT students towards disabled people?

how accepting of disabled people are OT students, would they be willing to work with disabled people as colleagues?

is there a hierarchy of relationships for people with different impairments?

what does the 'professional' attitude mean in practice?

how does this 'professional' attitude develop?

what factors influence its development?

does contact with disabled people have any effect on attitudes?

do OT students express attitudes and values which oppress or empower their disabled clients?

Design

The design chosen for this study was a longitudinal case study, drawing together both quantitative and qualitative methods of data collection, in an integrated methodology, in order to give as broad a picture as possible of the attitudes of OT students towards disabled people and in order to address the research questions identified above.

The main focus of the study was to follow one cohort of OT students through their OT education and to gather both quantitative data (from the whole student cohort, the main questionnaire) and qualitative data (from a sub group of the cohort, the cohort interviews). This longitudinal part of the study would gather data to address the majority of the research questions. However, to be able to identify the core theme of a 'professional' attitude it was necessary to have some means of comparing the attitudes of OT students with those of a more general student population. For this reason data were gathered from a sample of non-OT students at Oxford Brookes University (OBU). Because of the nature of access to the non-OT student population it was not possible to follow a cohort of non-OT students throughout their degree programmes. A comparative longitudinal cohort study would have been ideal. However, a quasi-longitudinal approach was used for this aspect of the study, with data gathered from separate year groups of non-OT students. The data collected from non-OT students consisted of the quantitative, main questionnaire. It was not considered appropriate to interview the non-OT students, for two reasons. Firstly, the interviews were aimed at exploring, primarily, attitudes in a practical setting. As the non-OT students were explicitly chosen from non-professional programmes, discussion of attitudes in practice was inappropriate and interview data would have added little to the study. The second reason was pragmatic and practical. Access to non-OT students was complex and negotiating and carrying out interviews would not have been feasible or possible. The aim of

collecting data from non-OT students was to provide a baseline; this was best achieved through a quantitative approach.

As the study progressed it was deemed appropriate to gather data from a wider range of sources, using other research tools, in order to triangulate the data and gain as broad a picture as possible of OT students' attitudes. Tringo's (1970) Disability Social Distance Scale was used to gather data from separate 1st, 2nd and 3rd year OT students. This, again, forms a quasi-longitudinal aspect of the study. Other aspects of the research are cross-sectional in nature, gathering data to provide a snapshot of attitudes at one point in time. The personal/professional questionnaires, the faculty questionnaire and the data collected from students who had taken module 1528: Practice in Partnership (Disability) *(see Appendix I)* make up the cross sectional aspects of the research.

Data collection

Table 5:1 gives an overview of the timetable for the data collection, differentiating between the cohort and non-cohort data and, also, the qualitative and quantitative data. The table also identifies the longitudinal and cross-sectional strands of the study, as follows:

the true longitudinal, cohort, study [1];

the quasi-longitudinal studies:

using the main questionnaire with non-OT students [2];

using the disability social distance questionnaire [3];

the cross sectional studies:

using the personal/professional questionnaire [4];

the faculty questionnaire [5];

using the 1528 questionnaire [6];

using the 1528 interview [7].

Table 5:1: The timetable of data collection

	OT cohort data	*other data*
year 1:		
autumn term	1st year questionnaire[1]	
spring term	*Cohort interview 1* [1]	
summer term		
year 2:		
autumn term	*1528 questionnaire* [6]	
spring term		
summer term	2nd year questionnaire [1] *cohort interview 2* [1]	
year 3:		
autumn term		personal/ professional questionnaire [4] **a** *1528 questionnaire* [6] **a**

spring term		non-OT questionnaire [2]
summer term	3rd year questionnaire [1] *cohort interview 3* [1]	
year 4: autumn term		non-OT questionnaire [2]
spring term		faculty questionnaire [5]
summer term		non-OT questionnaire [2] disability social distance questionnaire [2nd & 3rd year OT] [3] **b** *1528 interview* [7] **a**
year 5: autumn term		disability social distance questionnaire [1st year OT] [3] **b**

italic indicates qualitative data
bold letters indicate respondent group, these are explained below

The author acknowledges that this study is highly complex, with a number of strands, and that following the various parts of the study can be confusing. In order to aid the reader, the author will attempt to outline which parts of the study address the particular research questions. The research questions are

listed below with the various strands identified by number (as at the beginning of the 'data collection' section of this chapter):

- what, amongst OT students, is a 'professional' attitude towards disabled people? [1, 2, 3, 4]
    - are the attitudes of OT students towards disabled people any different from those of other students? [1, 2, 5]
    - do these attitudes change over time? [1]
    - are there any differences in the 'personal' and 'professional' attitudes of OT students towards disabled people? [4]
    - how accepting of disabled people are OT students, would they be willing to work with disabled people as colleagues? [1, 3, 6, 7]
        - is there a hierarchy of relationships for people with different impairments? [3]
        - what does the 'professional' attitude mean in practice? [1]
- how does this 'professional' attitude develop? [1]
    - what factors influence its development? [1]
    - does contact with disabled people have any effect on attitudes? [1, 2, 4, 5]
- do OT students express attitudes and values which oppress or empower their disabled clients? [1, 4, 6, 7]

Sample and respondents

The main group of respondents for this study was OT students. A convenience or, as Judd, Smith and Kidder (1991: 134) call it, an 'accidental sample' was used.

> In accidental sampling, we simply reach out and take the cases that are at hand, continuing the process until the sample reaches a designated size. Thus, we may take the first hundred people we meet on the street who are willing to be interviewed. Or a college professor, wanting to make generalizations about college students, studies the students in his or her classes. (Judd, Smith and Kidder, 1991: 134)

Thus, the researcher, a university lecturer wishing to make generalisations about OT students used the students from one year group as her cohort, giving a longitudinal sample. The entire student year group was used to gather the questionnaire data.

To triangulate the data, other OT student year groups were also used to gather some questionnaire data. Again, accidental sampling was used. The first additional group (**a** in Table 5:1) were in the first term of their second year of study when the data were collected, they completed the personal/ professional attitudes questionnaire, the 1528 questionnaire and the 1528 interview. The final additional student group (**b**) was another quasi-longitudinal sample of first, second and third years who completed the social distance questionnaire.

The main student cohort was also used as the population from which the interview respondents were chosen. Quota sampling was used to ensure the 'inclusion of diverse elements of the population and to make sure that they are taken account of in the proportions in which they occur in the population' (Judd, Smith and Kidder, 1991: 134). The student group fell naturally into three subgroups based on age; school-leavers (students who had come to the university straight from school and were aged 18/19); young mature students (students who had not come to university straight from school and were aged 20 - 25) and the mature student group (students who were over 25). These groups made up 50%, 30% and 20% of the student cohort respectively. Age was chosen as the key variable for the interview respondents as previous research on OT students (Nordholm & Westbrook, 1987; Fleming et al., 1997) has found that OT student groups are homogenous in terms of social class, ethnicity and education. One subgroup who were not included in the quota sampling were male students. The number of male OTs is small and within any year group the number of male students is less than 5%. Although it would be interesting to include this subgroup to explore gender differences in attitudes in more depth, it was felt that this was beyond the scope of this study.

The purpose of the interviews, and thus the interview sample, was not to gather statistically representative and generalisable data, but rather to gather data which were qualitatively credible and transferable (Krefting, 1991). Credible data are data which present a true picture of the phenomenon under

investigation. Whilst transferable data are data which present a picture of the phenomenon which is recognisable to the reader. The data from this qualitative part of the study are, by their very nature, specific to the research context. It is the job of the researcher to present data which, as truly as possible, represent OT students at Dorset House/Oxford Brookes in the early 1990s. These data can then be used to generate theory and 'reveal the unique meanings of human experience within human environments' (DePoy & Gitlin, 1994: 128). It is for the reader to apply these data to her/his own context and to test the trustworthiness of the findings against that context. Given the qualitative nature of this part of the study, a sample which represented 10% of the larger cohort group was deemed to be sufficient to provide the in-depth view which qualitative data can give (DePoy and Gitlin, 1994).

Ten students were chosen to form the interview sub-cohort from the main cohort, 5 school-leavers, 3 young matures and 2 mature students. In the 1st year 9 of the interview cohort were interviewed at the beginning of the Spring term. One student (a school-leaver) did not respond to the request to be interviewed and left the course during the term. Another student (a mature student) left the course at the end of her 1st year, after fieldwork placement, and having been interviewed once. It was not considered appropriate to replace these two respondents at this stage of the study. The remaining 8 were interviewed again in the Summer term of their 2nd year and finally in the Summer term of their 3rd year.

It had been suggested (Annandale and Stewart, 1998) that follow-up interviews should have been considered once this group of students had qualified as occupational therapists, to explore their attitudes once they had been in professional practice for some time. The focus of this study is on the attitudes of OT *students*. Whilst it might be interesting to explore how, or indeed whether, these students' views had changed once they became part of the 'real' world of OT practice, it would divert the focus away from the nature of students' attitudes. Exploring practising OTs' attitudes towards their disabled clients may well be an interesting, and enlightening, offshoot of this study. It would not add anything to this current study. On a practical note, follow-up interviews with this group of students would prove extremely difficult. Students, once they have left university, are notoriously difficult to locate, and rarely respond to communications from their alma mater, having scattered to the four corners of the country and beyond (OBAA, 1999).

To provide a means of comparing the attitudes of the OT student cohort to those of non-OTs, and thus establish whether there was such a thing as a 'professional' attitude to disabled people, it was necessary to identify a suitable non-OT student population. It was decided to use two student groups as the comparison groups. One group of students were also involved in a professional socialisation process, these were students within teacher education. The final groups of students were non-professional undergraduate students; these were students taking politics and psychology modules. The sampling process for these groups was again accidental sampling, with

students in their first and final years of study, giving a quasi-longitudinal sample. The reasons for gathering solely questionnaire data from this group have already been discussed.

To further triangulate the data and to test Brillhart et al's (1990) findings that nursing faculty held the least positive attitudes towards disabled people, the OT teaching staff (faculty) were also given the main questionnaire. The sampling used was convenience and cross-sectional, as all members of the OT faculty were asked to complete the questionnaire. These data were gathered to explore the possible sources of influence for the OT students during their professional socialisation, in terms of the similarities between OT students' and OT faculty's attitudes towards disabled people. Whilst it might have been interesting to explore OT faculty attitudes in more detail though the medium of interviews, it was not felt that this was appropriate to the *student* focus of the study.

Access

The question of access is always of great importance when considering sampling within qualitative research. Access involves not only getting permission to do a piece of research within a setting, but also negotiating access at a number of different levels within that institution. Access also involves establishing trust between researcher and respondent so that responses will be a reflection of what the respondent thinks and not just what they think the researcher might want to be told (Burgess, 1984).

In this study access posed a number of problems. Within the School of Occupational Therapy access to students might, initially, appear to pose no problems. Being a member of the faculty I had free access to groups of students during lectures and seminars. Also, because the research was seen as of interest to the School, I had permission from the Head of School and the School Research Committee to interview and give questionnaires to both students and colleagues. However, because I am a member of the faculty, this did pose problems.

For the students I represent authority and have a knowledge of occupational therapy theory and practice, with the major consequence that they might have felt that there was an expected or 'right' answer to the interview questions or the questionnaires. This did not, however, appear to be the case. Students were very willing to tell me that aspects of the main questionnaire (especially the semantic differential scale) were “rubbish” or “impossible to answer”. Students in the interviews, also, were very frank about their ideas and did not appear to be giving me the responses that I might have been perceived to 'expect'. The interviews were, as far as possible, conducted in a neutral setting within the University (i.e. not in my office).

To avoid issues of coercion, respondents for the interviews were identified and then contacted by means of a note in their pigeonhole explaining the study and interview process and asking them to participate. Questionnaires for the main study and the personal/ professional attitudes were distributed to

each student via their pigeonholes. For these aspects of the study it was necessary to be able to compare the data for individual students (i.e. data from student *a* in her/his 1st, 2nd and 3rd year needed to be compared, or student *b*'s personal and professional ATDP scores needed to be compared), to facilitate this, questionnaires were given numbers which related to individual students. Where no identification was necessary (i.e. the disability social distance questionnaires and the 1528 questionnaires) questionnaires were distributed at the end of a lecture and students were asked to return the completed questionnaires to a designated place.

For the non-OT student groups, access was negotiated via colleagues in other Schools within the University. These colleagues distributed questionnaires on my behalf during teaching sessions, and again asked for completed questionnaires to be returned to a designated place. Distribution of questionnaires to non-OT students was, therefore, out of my control and thus response rates were disappointingly lower.

Ethical issues

Some of the ethical issues that arose in this study have already been discussed. However one issue of access is worth considering here. Kidder and Judd (1986: 461) list ten 'questionable practices involving research participants'. One of these questionable practices is coercing people to participate. Because I might have been seen as an authority figure I was very

careful that the respondents felt no obligation or coercion to be interviewed or to complete the questionnaires.

A second ethical issue is confidentiality and anonymity. All the respondents, both for the interviews and the questionnaires were guaranteed anonymity and that confidentiality would be respected. Again this was particularly important with the interview group, as students often feel that anything they say to a member of the teaching staff has the potential to become staff-room gossip. I was constantly impressed with how honest the respondents were and how much they were prepared to reveal to me about their feelings about disability and working with disabled people.

Some of the questionnaire data were totally anonymous as questionnaires were distributed and completed during class time with no identifying marks on the questionnaire. Other questionnaires were coded to allow follow-up or comparison of responses between different questionnaires. These questionnaires were processed anonymously, the data was re-coded and the lists of names and numbers were destroyed.

Data collection methods

Two methods of data collection have been utilised in this study:

1) semi-structured interviews;

and

2) questionnaires.

The reasons for the choice of an integrated methodology with the use of both quantitative and qualitative data collection methods have already been explored. This section will outline the reasoning behind the use of the specific data collection tools and will outline the development and evolution of the interviews and questionnaires as used in this study.

The choice of data collection methods

The methods of data collection used in this research were a series of semi-structured interviews with a small group from the OT cohort and a series of questionnaires to OT and non-OT students.

The value and disadvantages of questionnaires

There are advantages and disadvantages in using questionnaires as data collection tools. Judd, Smith and Kidder (1991) identify the advantages as low cost, lack of interviewer bias, immediacy of response and anonymity, and the disadvantages in terms of the quality of response. Poor quality responses can be due to a low response rate, in this case students might not return their questionnaires, although this can be overcome by administration to a 'captive' audience, e.g. questionnaires can be given out to students during a lecture. Completeness and accuracy of responses may suffer, students might ignore questions they do not wish to answer or tick the box that seems to be the 'right' or politically correct answer. Responses might also suffer because questions are misunderstood.

It might seem from this discussion that the disadvantages outweigh the advantages of questionnaire use. However, in order to gather data from a large number of respondents and to allow comparison between the groups to establish a baseline it seemed that a questionnaire was the most appropriate data collection tool for this aspect of the study. The use of existing questionnaires would also allow comparison of the data from this study with the findings of other, similar, studies and would thus increase the transferability and trustworthiness (Krefting, 1991) of this study.

The value and limitations of semi-structured interviews

There are advantages and disadvantages to interviewing. Kidder and Judd (1986: 225) highlighted the major advantages as

> the ability of the interviewer to notice and correct the respondent's misunderstandings, to probe inadequate or vague responses, and to answer questions and allay concerns (all of which) are important in obtaining complete and meaningful data'.

In semi-structured interviews one clear advantage is that interesting lines of thought can be followed up and explored in some depth (Ogier, 1989). For Hakim, the great strength of qualitative research and the interview was 'the validity of the data obtained' (Hakim, 1987: 27). Because respondents are interviewed in depth, and ideas can be followed up and misunderstandings

clarified, the results can be 'taken as true, correct, complete and believable reports of their views and experiences' (Hakim, 1987: 27).

The use of open questions within an interview framework does not constrain the respondent's response or confine them to an over simplified response. Open questions, because they allow the individual to express themselves freely, are also more motivating to the respondent (Kidder & Judd, 1986) and may capture their interest more than closed questions or a more structured format. Thus, in the case of this study where ideas about disability were being explored, a semi-structured interview seemed the most suitable method of data collection for this aspect of the study.

However, it must be appreciated that interviews are not without their disadvantages. According to Hakim (1987) the main weakness is that, whilst looking at a few respondents in considerable depth, the small numbers of respondents cannot be representative. The very presence of the interviewer may influence the responses. By non-verbal behaviour the interviewer may indicate that she approves or disapproves, agrees or disagrees, with something the respondent has said (Ogier, 1989) so that the interviewer's assumptions may be fulfilled. This could particularly be the case in a semi-structured interview where non-verbal behaviour may encourage the respondent to develop a theme of particular relevance to the interviewer's expectations, whilst ignoring other aspects which may not fit the interviewer's assumptions. The respondent might wish to present him or herself in a

favourable light and so say what s/he thinks the interviewer expects to hear. In the case of this study the respondents are students and they may wish to impress their tutor with their knowledge or politically correct ideas and so attempt to give the 'right' answer rather than their own views, this discussion will be continued in subsequent chapters.

Designing the questionnaires

The pilot study

The development of the questionnaire began with a pilot study. During their first year of undergraduate study OT students at OBU take a module called 'The Sociology of Impairment, Disability and Handicap'. This module allows students to explore their knowledge and understanding of the experience of disability. The module consists of 2 aspects, a theoretical component and an experiential component. During the theoretical part of the module the students explore theory and research on the impact of disability on the individual and society. At the time of this study the experiential component involved not only experiencing simulated disability (going into Oxford in a wheelchair), but also talking to a disabled person about their experiences of being disabled and seeing how this ties into the theory.

This module can be seen as a miniature replica of the whole of the BSc course, in terms of the processes involved in influencing attitudes towards disabled people. For this reason it seemed appropriate to use this module as the basis for developing the research tools for this study. The method of data

collection chosen for the pilot study was a modified form of the ATDP. This tool was chosen as the pilot study for a number of reasons. The ATDP is a commonly used tool, it has been found to be both valid and reliable and has a range of established norms against which results can be compared. It also happened to be fairly easily accessible.

The way the ATDP was utilised was to use the shorter 20 item questionnaire (Form O) and a 5-point response scale of 'strongly agree', 'agree', 'don't know', 'disagree' and 'strongly disagree'. This is not quite the response scale the questionnaire should have. The correct 6-point scale was employed when the ATDP was used as part of the main questionnaire in the final study.

The questionnaire was administered twice, once at the beginning of the Sociology module and again at the end of the module. The first questionnaire asked students to say what they thought the term 'physical disability' meant and the second questionnaire asked students if they thought their attitudes had changed and what factors had influenced these changes. Students were also asked to put an identifying number onto their questionnaire so that the second questionnaires could be matched and compared, to see if individual students' attitudes had, in fact, changed.

(Appendix II contains a copy of the first pilot questionnaire; Appendix III contains a copy of the second pilot questionnaire)

Questionnaires were distributed to all first year students, which meant 96 questionnaires went out. 71 of the first questionnaires were returned and 73 of the second. Of those only 56 could be matched to the first questionnaire, this is partly due to different students returning the questionnaire and also due to incorrect identification numbers being used. A scoring system was devised with 'strongly agree' rating 5 and 'strongly disagree' rating 1. For some items, the scoring needed to be reversed to indicate a positive attitude. The maximum score possible was 100. This is not the standard ATDP scoring system, due to the use of a non-standard response scale. The mean scores for both questionnaires were calculated. The mean for questionnaire 1 was 75.7, and for questionnaire 2 it was 77.1. The range of scores for questionnaire 1 was 63 to 92, and for questionnaire 2, 64 to 89. Not very large differences, so it was no surprise that statistical analysis of the result did not reveal any significant differences.

(Appendix IV contains the analysis of these data)

In the second questionnaire students were asked whether they thought their attitudes had changed. A totla of43 students said 'yes' their attitudes had changed and become more positive and 30 responded that they had always been positive and seen disabled people as individuals and not really different from anyone else. But again statistical analysis revealed that the 'yes' and 'no' groups were not significantly different in their responses to either questionnaire, nor had either groups' attitudes changed significantly over the

module. Interestingly the 'no change' group were no more likely than the 'yes' group to produce the same answers for both questionnaires, and one might assume that if an individual's attitudes have not changed s/he is more likely to respond, say, 'strongly agree' to the same statement in both questionnaires than some one who feels that her/his attitudes have changed.

Looking at the qualitative data from the second questionnaire and particularly from the 43 respondents who felt that their attitudes had changed, we find that, for the wheelchair exercise (going shopping in Oxford) and the interview with a disabled person, 49% and 65%, respectively, felt that these experiences had been key factors in changing their attitudes. Knowledge of the problems of disability, either with specific reference to the sociology module or to the course in general, was identified by 70% of the group as a reason for their changing attitudes. This gives some qualitative if not quantitative support to the notion that knowledge and contact can influence professional attitudes.

Although the pilot study did not demonstrate a significant change in attitudes over a relatively short period of time, it did clarify the researcher's thinking on the design of the questionnaire for the main study. The pilot study highlighted the need to use any existing questionnaire correctly to ensure both validity and reliability, and to facilitate comparison of the results with other published research.

The ATDP

The ATDP, as a measure of attitudes towards disabled people, appears to be the best scale to form the basis for this research tool. The ATDP is well established and has been used in previous research on OTs' attitudes (Lyons, 1991; Estes et al., 1991; Kirchman, 1987; Westbrook & Adamson, 1989; Lee et al., 1994). However the ATDP exists in 3 forms (Forms O, A & B) and all 3 variations appear to have been used in previous research. Form A was used by Estes et al. (1991), Lyons (1991) and Lee et al. (1994). Westbrook and Adamson (1989) used Form O and Kirchman (1987) failed to identify which form she used. It, therefore, seemed sensible to use the ATDP-A in this research, as it would allow comparison of results with existing research data.

The ATDP does, however, seem to be somewhat narrow in its measurement of attitudes as it appears to address the affective and, possibly, cognitive aspects of the attitudes without addressing the behavioural aspects which are part of any attitude. It seemed sensible, therefore, to design a questionnaire which covered all these areas.

The Social Distance Scale

The behavioural aspect of an attitude can only be partially addressed in a questionnaire as respondents may say one thing and do something completely different. Behaviour lends itself rather more to observation. However in an attempt to address the behavioural aspect of attitudes towards

disabled people a social distance scale was be included in the research tool. Bowman (1987), using a social distance scale, found that as social distance decreased and intimacy increased willingness to associate with a disabled person decreased. A social distance scale, similar to the one used by Bowman, was included in this research tool. The responses to this scale could be quite telling in terms of the oppression model of disability. If OTs are part of the oppression of the disabled i.e. by doing 'good', teaching the disabled their place in the world and helping to keep them there, then it might be argued that whilst an OT student might hold a positive attitude, in terms of her/his ATDP score, s/he would be less willing to go out with, share a house with or be employed by a disabled person. Going out with or sharing a house with a disabled person implies not just intimacy but equality, and being employed by someone with a disability implies a reversal of the power relationship which might not be acceptable to an individual who is used to the power of the therapeutic relationship. The second part of the questionnaire, therefore, is a social distance scale, where respondents indicate, on a 3 point scale of 'definitely', 'maybe' and 'never', whether they would be prepared to 'work with a physically disabled person', 'spend leisure time with a physically disabled person', amongst other things.

The Suitability for Occupational Therapy Scale

The power of the professional and the notion of acceptable social distance can also be seen in terms of whom is deemed suitable to train as an OT. French (1987) investigated the attitudes of physiotherapists to the recruitment

of disabled people into their profession. Interestingly she found that certain characteristics (e.g. obesity) which went against the stereotype of the typical physiotherapist as active and sporty were viewed more negatively than more substantial disabilities. There is some evidence (French, 1986, Bagley, 1971, Sutherland, 1981) that not only are disabled people not encouraged to join the caring professions, they may be actively discouraged. It would be interesting to continue to explore the behavioural aspects of attitudes towards disabled people by seeing how welcoming OT students might be to disabled people as members of their profession, and therefore crossing the great divide between therapist and patient. The 3rd section of the questionnaire looks at whether people with certain conditions or disabilities are suitable to train as an OT. Responses are recorded on a 4-point scale of unsuitable to suitable.

The Disability Semantic Differential Scale

Attitudes and stereotypes are very closely interwoven and one method of getting respondents to articulate their stereotypes is by means of a semantic differential. Osgood et al. (1957) described the semantic differential as a method of measuring the meaning of an object or a concept to an individual, and, whereas, the ATDP can be seen as a way of looking at how much a respondent sees a disabled person as being like 'normal' people, a semantic differential can provide a more evaluative picture. Semantic differentials have been used in research on attitudes towards disabled people (e.g. Freeman, 1988; St Claire, 1986). Freeman found that as well as positive attitudes the

semantic differential revealed elements of paternalism and superiority and a stereotype of disabled people as disadvantaged, dependent and of low status. St Claire (1986) used a semantic differential to explore the constructs and beliefs about mentally handicapped people, and especially to compare the constructs of professionals and lay people. In order to provide as broad a picture as possible a semantic differential was included in this research tool. Any semantic differential consists of a series of bipolar constructs which are rated on a scale. The scales used can vary from 5 to 11 points, for this research tool a 6 point scale was chosen, thus avoiding a mid point, and, in common with the ATDP, not allowing respondents the option of opting out with a mid point or 'don't know' response. The bipolar constructs should consist of evaluative, potency and activity scales, thus giving the three underlying attitude dimensions (Kidder & Judd, 1986, Robson, 1993). The evaluation dimension consists of favourable/unfavourable constructs e.g. valuable/worthless, accepted/misfit, giving an overall positive or negative view of the object (disabled people); the potency dimension consists of constructs illustrating the respondent's perceptions of the potency or power of the disabled person e.g. helpless/competent, tough/vulnerable, and the overall importance of the object (disabled people); and the activity dimension consists of constructs such as extrovert/introvert, unco-ordinated/graceful, which illustrate the respondent's beliefs about the activity and abilities of the disabled person. An attempt was made to ensure that the poles that might be perceived as the more positive end of the construct are not all on the same

side of the scale. The fourth section of the questionnaire is a semantic differential.

The questionnaire concludes with biographical information such as age, stage of training or course and sex, which will allow these variables to be considered in the data analysis. A question on the contact the respondent has had with physically disabled people was also included to allow the variable of contact outside the professional relationship to be explored. This last question also asked if the respondent her/himself is disabled, as French (1987) has noted, people who are themselves disabled bring personal experience and added knowledge to their professional skills and attitudes.

(Appendix V contains a copy of the final questionnaire)

Although it may appear that the research tool is both long and complex, it was hoped that it would provide a breadth of data and, therefore, be sufficiently subtle as to allow differences and changes in attitudes to be noted and possibly highlight areas which could be developed into a screening tool for potential applicants to the caring professions. For, as both McDaniel (1976) and Yuker (1977) have argued, people with negative attitudes towards disabled people should be excluded from these professions.

Designing the interviews

The second approach to data collection was using a series of in-depth, semi-structured interviews with a small group from the OT cohort. With the interviews it was hoped to get a depth of data and to explore issues beyond the rather general responses to the questionnaire.

Although the interviews evolved over the 3 years of the study, certain themes were explored during each interview. The interviews were used to explore definitions of disability and exactly whom the students thought of when they talked about 'disabled people'. A second theme that underpinned the interviews was how the students perceived and responded to disabled people in different settings, to see if there was a difference between the friend relationship and the professional perceptions and relationship.

The first interview

In the first interview, to explore definitions of disability, each respondent was asked to say how they would define disability to some one who knew nothing about it, a child for example, and then to talk about someone that they knew who was disabled. To explore perceptions and responses to disabled people in different settings and the difference between friend relationships and client/professional relationships, a number of scenarios were given to respondents and their responses to these situations were discussed. The scenarios were: sharing a house with someone who is disabled; working with someone who is disabled; and then 2 scenarios involving patients, one a

woman who said she did not want to get dressed when they went along to do dressing practice and the other a young patient who is always late because her main concern is with looking nice. The two client/professional scenarios were used to explore how much autonomy respondents might feel they could give their patients, or how far were they interested in caring for, and doing things with, a patient. This led on to exploring the different priorities that might exist when treating a patient, those of the patient, those of the therapist and those of the health care organisation. At the end of these interviews respondents were asked about the problems the student group might have had in completing the questionnaire, especially the semantic differential which asked them to create a stereotype. Respondents were also asked whether they felt that their attitudes had changed since they began the course.

The second interview

The second interview followed similar themes, and also explored what 'independence' meant both for the respondent and for her patients. During the scenarios the researcher very deliberately talked about a 'patient', and then asked respondents which term they felt most comfortable with and what the different words implied for them in terms of the nature of the relationship they might have with their 'patient' or 'client'. The idea of 'professional curiosity' and whether, if they saw someone in a wheelchair whilst they were out shopping, they thought of them in terms of a condition, whether they noticed them at all and how they responded, was also discussed.

The final interview

The final interview revisited the definitions and scenarios and explored issues of empowerment and what it might feel like to have a patient or client say 'thank you very much, I don't need you any more!'. Also, following a controversial paper by Abberley (1995), the issues of what is successful and unsuccessful treatment/intervention were explored. As the respondents were at the end of their degree studies they were then asked to reflect upon their course and how they felt their ideas and attitudes might have changed and been affected during the 3 years.

(Appendix VI contains copies of the interview guides)

Other data collection tools

Practice in Partnership interview and questionnaire

As the study progressed it became apparent that, whilst the main questionnaire was gathering a breadth of data, other issues needed to be addressed. The module 'Practice in Partnership (Disability)', which students could choose to take in the first term of their second year, gave students an opportunity to continue to address issues pertinent to this study. The focus of the module is on working in partnership with disabled people and two members of the module team are disabled. This module could, therefore, have a major influence on students' attitudes. A short questionnaire was developed to give students who had taken this module the opportunity to reflect on their experiences. This was followed up with a focused, but

unstructured, interview with a small group of third year students who had taken the module.

(Appendix VII contains copies of the questionnaire and interview guide)

The personal/professional attitudes questionnaire

Vargo and Semple's (1988) study and Speakman's (1989) research highlighted the possible differences between personal and professional attitudes towards disabled people. The research, however, seemed inconclusive with Vargo and Semple (1988) finding professional attitudes to be more positive and Speakman (1989) proposing that professional attitudes might appear more negative. The need to differentiate between personal and professional attitudes was highlighted and a questionnaire using the ATDP-A was developed to investigate this issue.

(Appendix VIII contains copies of the personal/professional questionnaires)

The Disability Social Distance Scale

Lyons and Hayes' (1993) study of OT students using Tringo's (1970) Disability Social Distance scale highlighted the possible limitations of the social distance scale in the main questionnaire. Whilst the social distance scale in the main questionnaire explored a wide range of relationships, it did not provide the breadth or depth of information possible with the Disability

Social Distance scale. It was, therefore, decided to use this scale in a questionnaire to a quasi-longitudinal sample of OT students.

(Appendix IX contains a copy of the social distance questionnaire)

Chapter 6

PROFESSIONAL ATTITUDES TOWARDS DISABLED PEOPLE:

QUANTITATIVE RESULTS

This chapter will give an overview of the quantitative data obtained in this study. This data will be used to address the following research questions:

what, amongst OTs students, is a 'professional' attitude towards disabled people?

are the attitudes of OT students towards disabled people any different from those of other students?

do these attitudes change over time?

how accepting of disabled people are OT students, would they be willing to work with disabled people as colleagues?

are there any differences in the 'personal' and 'professional' attitudes of OT students towards disabled people?

is there a hierarchy of relationships for people with different impairments?

does contact with disabled people have any effect on attitudes?

In order to answer these questions the main questionnaire data, involving respondents from the OT student sample, the OT faculty and the non-OT students, will be presented first, followed by the personal/professional questionnaire data and finally the social distance questionnaire data.

Table 6:1, below, gives an overview of the potential sample size, actual number of respondents and response rate for each of the respondent groups. It was noted in the previous chapter that, because of problems of access and

availability, it was much more difficult to gather sufficient numbers of completed questionnaires from the non-OT student group, hence the much lower response rate. It is, however, still important to include this comparative data in the analysis. However, it will be noted that any conclusions drawn about non-OT students will be very tentative and that these data must be viewed with caution because of the limited number of respondents. The response rate for the social distance questionnaires with the 3rd year students is also surprisingly low, given that these were OT students. This was, again, due to problems of availability. Students in their final term of study tend to be involved in far fewer lectures and thus it was more difficult to ensure an adequate response rate. Again, these data must be viewed with some caution.

The original design for the OT main questionnaire part of the study was longitudinal, allowing comparison of any particular student's questionnaire data across the 3 years of study. However, due to a poor response rate in terms of matched questionnaires (e.g. student *a* returning all 3 questionnaires), this part of the study must be seen as quasi-longitudinal and each questionnaire analysed as though it was from a separate respondent. Only 31 respondents (34% of the OT cohort group) returned all 3 questionnaires (year 1, year 2, & year 3). The design for the personal/ professional questionnaire part of the study was a within-subjects design, whilst the social distance questionnaire part of the study was given to 3 separate year groups of students.

Table 6:1: Numbers and percentage of respondents for each part of the study

	sample potential	*number of respondents*	*response rate [%]*
Main questionnaire			
OT students			
1st years	100	70	70%
2nd years	92	65	70.65%
3rd years	92	64	69.56%
non-OT students			
1st years	94	46	48.93%
3rd years	92	23	25%
OT faculty	15	15	100%
personal/ professional questionnaire	98	66 *[45 matched, personal & professional data]*	67.34% *[45.91%]*
social distance questionnaire			
1st years	92	74	80.43%
2nd years	96	67	69.79%
3rd years	82	31	37.80%

NB This table gives an overview of the respondents for the 3 separate aspects of this study:

Main questionnaire
Personal/professional attitudes questionnaire
Social distance questionnaire.

The OT students for the separate aspects of the study were drawn form 3 separate, and distinct, cohorts (and intakes) of OT students.

Findings from the main questionnaire

The main questionnaire contained four sub-scales: the Attitudes Towards Disabled People scale form A (ATDP); a social distance scale; a section asking respondents to rate how suitable someone with a disability might be to train as an OT; and a semantic differential scale. The questionnaire was distributed to both OT (n=199) and non-OT students (n=69) and to OT faculty (n=15).

The analysis of the data from the main questionnaire will be presented as both descriptive analysis and inferential analysis. The inferential analysis of the data will use, mainly, non-parametric tests. Non-parametric tests have been chosen to analyse these data for two reasons. Firstly, the majority of the measures used in this questionnaire generate ordinal data. Whilst statisticians (Pett, 1997) agree that large ordinal data sets can be analysed successfully with parametric tests, this is not advisable when the number of respondents in the different conditions (or groups) is uneven, which is my second reason for rejecting parametric tests. One of the key variables within this part of the study is whether the respondent is an OT or non-OT student. However, with an imbalance between OT and non-OT students of 199:69, 70.3% of the sample being OT students, this would detrimentally effect the robustness of any analysis using parametric tests.

For the student respondent group, the average age was 22.82 (*sd*=5.13, range=18-45), faculty were not asked to state their ages. The proportion of female to male respondents was 250:33. 88.3% of the respondent group for

the main questionnaire were female. Table 6:2 gives an overview of the demographic details of the various groups.

Table 6:2: Demographic information for the main questionnaire

respondent group	*average age* *[sd]*	*female:male ratio* *[% female]*
OT students		
1st years	21.00 [4.33]	67:3 [95.7%]
2nd years	22.46 [3.95]	62:3 [95.4%]
3rd years	23.30 [3.84]	59:5 [92.2%]
non-OT students		
1st years	23.37 [6.19]	29:17 [63.0%]
3rd years	26.91 [8.03]	20:3 [87.0%]
OT faculty	*n/a*	13:2 [86.7%]

It will be noted that the average age of the non-OT students is slightly higher than that of the OT students and that the female:male ratio for the 1st year non-OT students is somewhat lower than for the OT student groups. Again, this indicates that the comparative results between OTs and non-OTs must be interpreted with some caution, as the two groups of respondents are not sufficiently well matched.

ATDP results

The response scale for each item of the ATDP is as follows:

+3 I agree very much

+2 I agree pretty much

+1 I agree a little

-1 I disagree a little

-2 I disagree pretty much

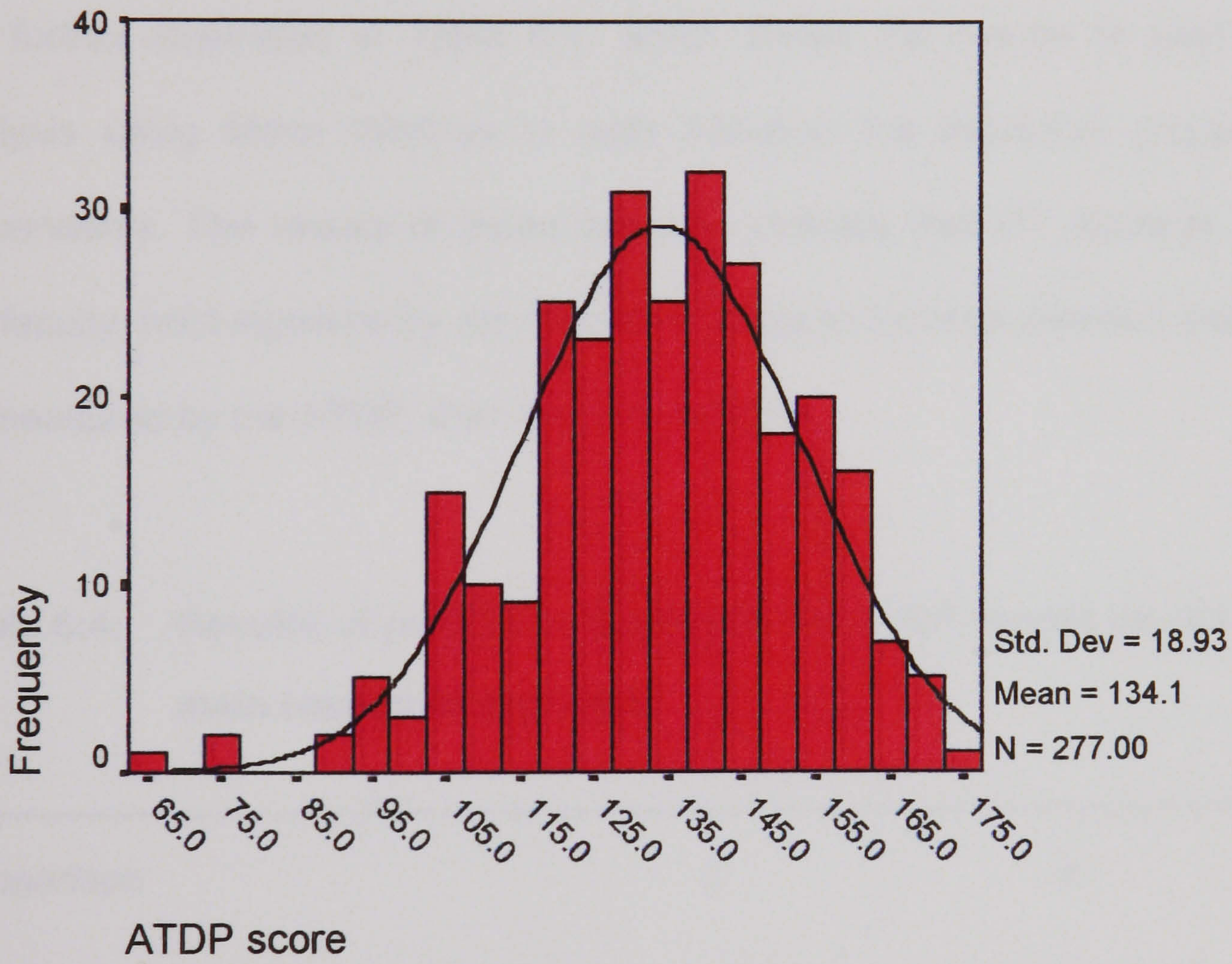
-3 I disagree very much.

To calculate the overall ATDP score the signs for the items indicating a positive attitude (items 5, 9, 12, 14, 17, 19, 21, 22, 23, 24, 25, and 29) are reversed to a negative. The algebraic sum of all the items is calculated. The sign of the sum is reversed and a constant of 90 is added to calculate the final score. The range of scores for the ATDP-A is 0 - 180, with a score of 90+ being seen as indicating a positive attitude. Yuker and Block (1986) calculated that the norm for the ATDP-A was 117.1.

As discussed in chapter 4, on attitudes towards disabled people, it is possible to divide the items on the ATDP into those addressing characteristics of disabled people and those indicating how disabled people should be treated. On the ATDP-A, items 2, 5, 6, 7, 8, 13, 21, 22, 23, and 28 can be identified as 'treatment' items, whilst the remaining items are the 'characteristic' items. Once the overall ATDP scores have been discussed these sub-scales will be analysed.

The mean ATDP score for all the respondents was 134.1 (*sd*=18.93, range=66-176) indicating predominantly positive attitudes towards disabled people amongst all groups of respondents. However, as Figure 6:1 illustrates, a number of respondents did have ATDP scores of less than 90, indicating a negative attitude towards disabled people amongst some of the respondents.

Figure 6:1: Histogram to illustrate the range of ATDP scores



There would appear to be some evidence to suggest that OT students and OT faculty hold significantly more positive attitudes than non-OT students.

Table 6:3: ATDP mean scores for the main respondent groups

respondent group	*mean ATDP score*	*standard deviation*
OT students [n=195]	137.18	17.04
OT faculty [n=15]	137.80	11.57
non-OT students [n=67]	124.11	22.03

Statistical analysis, using the Kruskal-Wallis test, indicates a significant difference between the groups (χ^2=18.366, *df*=2, p<0.000). These differences are further illustrated in Table 6:4, which shows the results of post hoc analysis using Mann Whitney U tests between the individual groups of respondents. The results of these analyses indicate that OT students, and OT faculty, hold significantly more positive attitudes towards disabled people, as measured by the ATDP, than non-OT students.

Table 6:4: Results of post hoc analysis of the ATDP scores for the main respondent groups

comparison	*z*	*p*
OT v. non-OT students	-4.188	<0.001
OT students v. OT faculty	-0.187	0.851
OT faculty v. non-OT students	-2.424	0.015

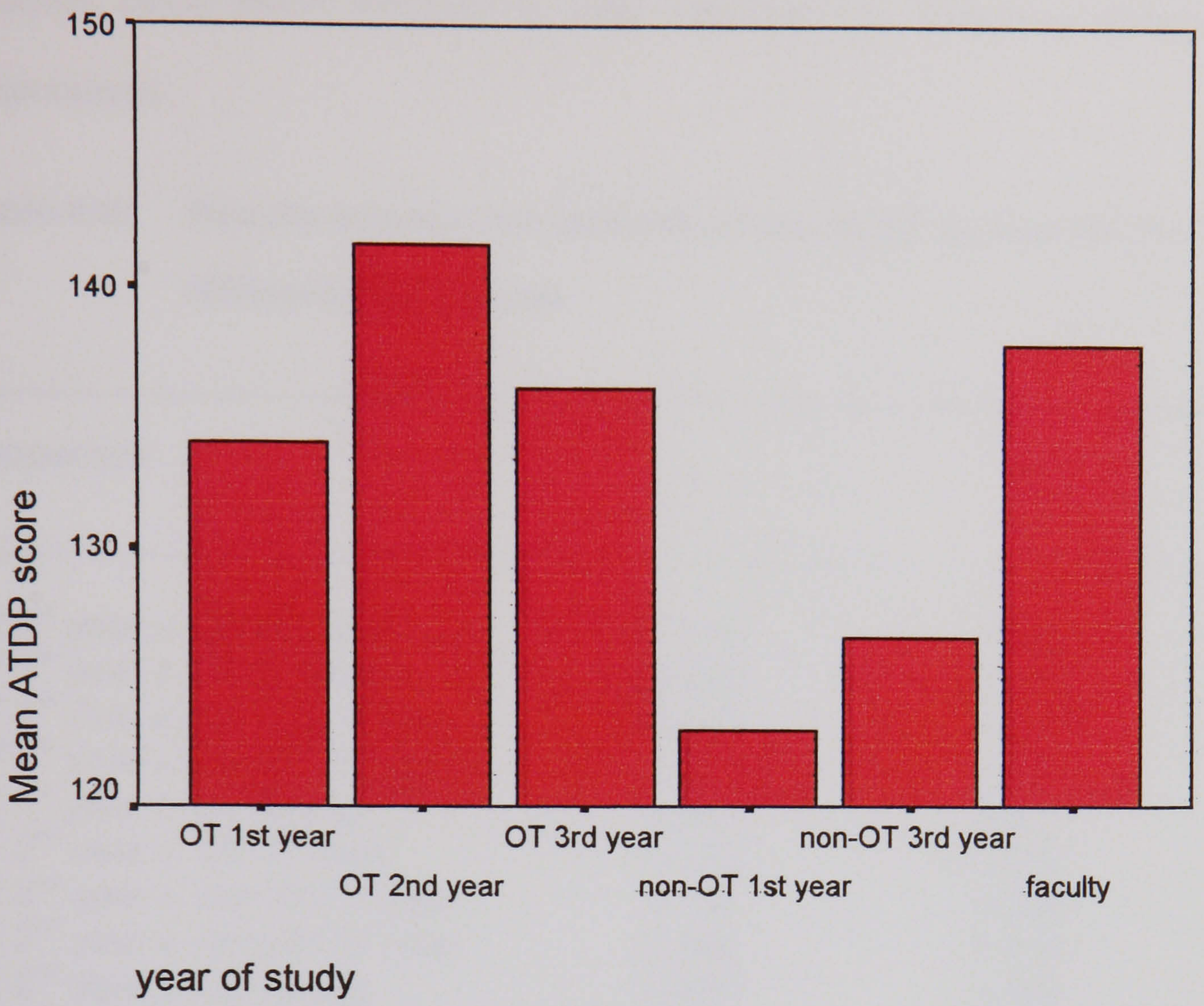
There is also some evidence that when the groups are subdivided into the various year groups there are significant differences in the attitudes of the different groups.

Table 6:5: ATDP mean scores for the different year groups

respondent group	*mean ATDP score*	*standard deviation*
OT students		
1st years [n=68]*	134.05	17.35
2nd years [n=63]*	141.61	14.91
3rd years [n=64]	136.12	17.97
OT faculty [n=15]	134.81	11.57
non-OT students		
1st years [n=45]*	122.93	24.05
3rd years [n=22]*	126.55	17.43

* indicates difference in respondent numbers from the respondent data given in Table 6:1, this is due to incomplete questionnaires, resulting in missing data.

Figure 6:2: Bar chart showing mean ATDP scores for the year groups



If we rank these mean scores, we find that the non-OT 1st year group are the least positive and the OT 2nd year group are the most positive in their attitudes:

non-OT 1st year:	122.93
non-OT 3rd year:	126.55
OT 1st year:	134.05
OT 3rd year:	136.12
OT faculty:	137.81
OT 2nd year:	141.61

Statistical analysis, using Kruskal-Wallis test, indicates a significant difference between the groups (χ^2=24.314, *df*=5, p<0.000). These differences

are further illustrated in Table 6:6, which shows the results of post hoc analysis using Mann Whitney U tests between the individual groups of respondents.

Table 6:6: Results of post hoc analysis of the ATDP scores for the different year groups

comparison	*z*	*p*
OT 1st year v. OT 2nd year	-2.431	0.015*
OT 1st year v. OT 3rd year	-0.540	0.589
OT 1st year v. non-OT 1st year	-2.552	0.011*
OT 1st year v. non-OT 3rd year	-1.625	0.104
OT 1st year v. OT faculty	-0.841	0.401
OT 2nd year v. OT 3rd year	-1.710	0.087
OT 2nd year v. non-OT 1st year	-4.161	0.000*
OT 2nd year v. non-OT 3rd year	-3.287	0.001*
OT 2nd year v. OT faculty	-0.920	0.358
OT 3rd year v. non-OT 1st year	-2.764	0.006*
OT 3rd year v. non-OT 3rd year	-1.866	0.062
OT 3rd year v. OT faculty	-0.550	0.582
Non-OT 1st year v. non-OT 3rd year	-0.494	0.621
Non-OT 1st year v, OT faculty	-2.255	0.024*
Non-OT 3rd year v. OT faculty	-2.167	0.030*

** indicates statistically significant differences*

From this table we can see that there is evidence to support the notion that OT students are more positive in their attitudes towards disabled people than non-OT students. There is some evidence that some changes in attitudes might be due to maturation as there is no difference in the attitudes of 1st year OT students and 3rd year non-OT students and there is a significant difference between 1st and 2nd year OT students. This might imply that, whilst OT students begin their course with more positive attitudes (as indicated by

the significant difference between 1st year OT and non-OT students), by the time any student finishes her/his course her/his attitudes will have become more positive. This might also be supported by the lack of significant difference between 3rd year OT and non-OT students. However, this is not supported by the analysis of the other groups. All other OT groups are significantly more positive than both 1st and 3rd year non-OT students. Also, whilst there is a difference between 1st and 3rd year non-OT students, this difference is not significant. It would, therefore, appear safe to conclude that OT students are more positive in their attitudes than non-OT students. However, the picture is more complex as there is also evidence of differences between the various OT groups, which will now be explored further.

It might seem logical to assume that within the OT course, attitudes towards disabled people are addressed and that the attitudes of students might, as a consequence of this, become more positive. Whilst there is evidence for attitude change within the various OT student groups, it does not always appear that attitudes become, or remain, more positive. If OT education had a simple enhancing effect on attitudes, the logical rank order for the results would be:

OT 1st year

OT 2nd year

OT 3rd year

Whereas the actual rank order is:

OT 1st year

OT 3rd year

OT 2nd year,

with significant differences between 1st and 2nd year OT students (z=-2.431, p=0.015), and approaching significant differences between the 2nd and 3rd year groups (z=-1.710, p=0.087). However, the difference between 1st and 3rd year OT groups is not significant (z=-0.540, p=0.589). Thus it would appear that, for this group of students, attitudes become more positive from the 1st year to the 2nd year of the OT course, possibly due to the experience of Fieldwork and with modules such as 1504: The sociology of impairment, disability and handicap and 1528: Practice in partnership. However, attitudes then appear to slip back and become slightly less positive between the 2nd and 3rd year. Perhaps this echoes Becker et al's (1961) findings, of increased cynicism amongst medical students, as they near the end of their medical education.

When the matched data from the OT student group are isolated, creating a true within-subjects longitudinal design, analysis (using the Friedman test) shows that there is a significant difference in the attitudes of students over the three years of the study (n=31, χ^2=6.607, df=2, p=0.037, 1st year ATDP x=132, 2nd year ATDP x=141.51, 3rd year ATDP x=137.13). When the comparative data for 1st and 2nd, 1st and 3rd, 2nd and 3rd as well as 1st, 2nd and 3rd year OT students are analysed, we find further significant differences between the groups. The difference between the ATDP scores for matched 1st and 2nd year OT students is significant (n=55, z=-3.416, p=0.001, using Wilcoxon Signed Ranks test); between the matched 1st and 3rd years the difference is approaching significance (n=36, z=-1.835, p=0.066); and

between the matched 2nd and 3rd year OT students, the difference is not significant (n=33, z=-1.722, p=0.085). These results indicate that attitudes improve from 1st year to 2nd year and, although they remain more positive than in the 1st year, there is some decrease in ATDP score between 2nd and 3rd year. These results could indicate that the learning and experience of the 1st year and the transition into the 2nd year is the most crucial time in terms of attitudes towards disabled people.

If we look at the sub-scales of the ATDP and at specific items of the ATDP we, again, find a complex pattern of differences between the various respondent groups.

Characteristic sub-scale

The ATDP-A consists of 30 statements, 20 of which can be seen as relating to perceived characteristics of disabled people. As there is no standardised method for analysing the sub-scales, it was decided to isolate the characteristic items (items 1, 3, 4, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 24, 25, 26, 27, 29 & 30) and, using a rating system of 1 for 'I disagree very much' to 6 for ' I agree very much' (items 1, 9, 12, 14, 17, 19, 24, 25, & 29 having reversed scoring), the total scores for the characteristic sub-scale were calculated. The potential range of scores was 0 – 120, with a high score indicating a positive attitude towards disabled people, i.e. seeing disabled people as no different to non-disabled people. The range of scores from the respondent group was 58 – 118, with a mean score of 94.5 (n=253, sd=10.85).

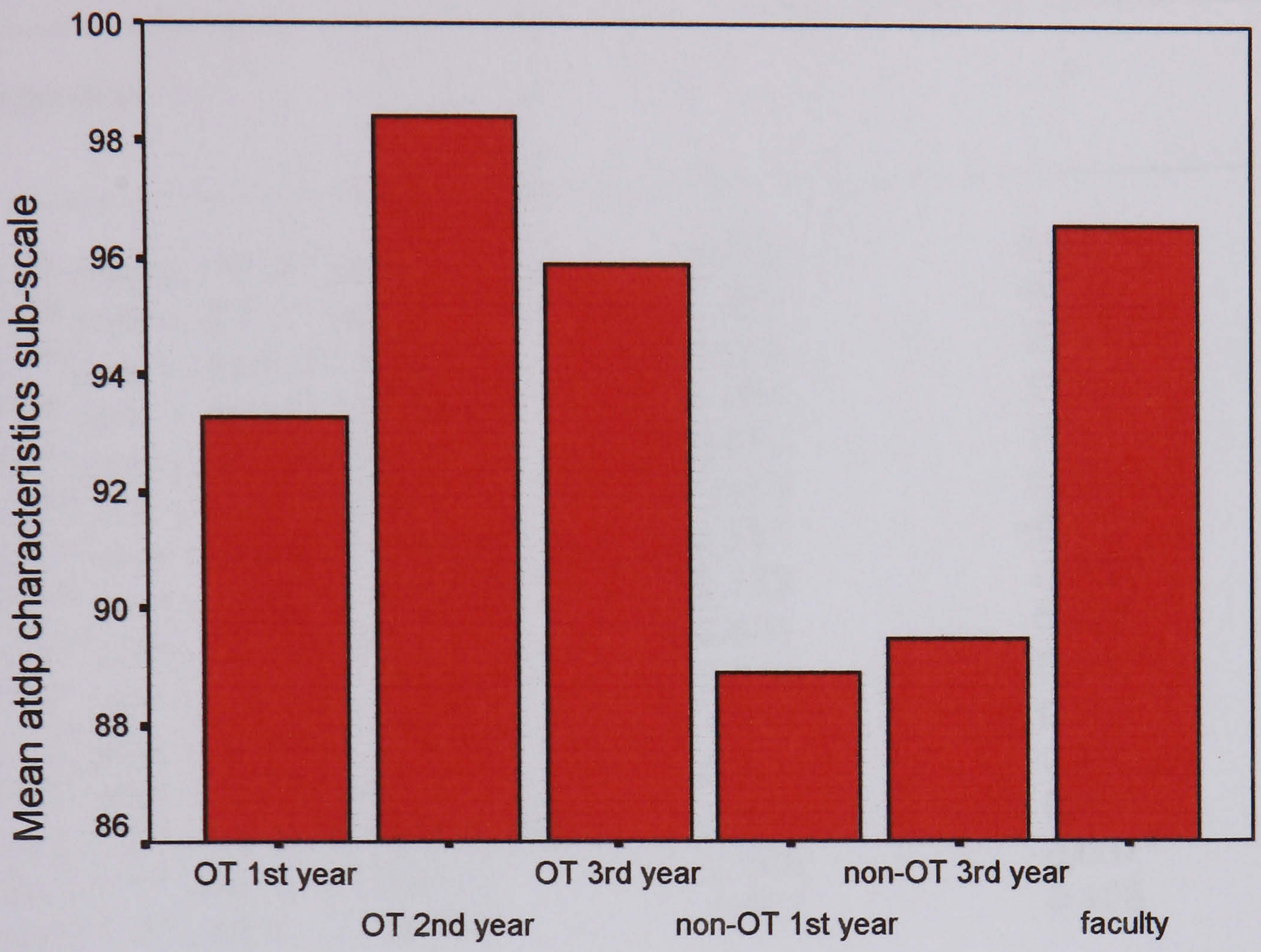
As Table 6:7 and Figure 6:3 show, there are marked differences between the mean sub-scale scores of the OT and non-OT students. The 1st year OT students' mean score is also somewhat lower than the scores of the other OT groups.

Table 6:7 ATDP 'characteristic' sub-scale mean scores for the different year groups

respondent group	*mean 'characteristic' sub-scale score*	*standard deviation*
OT students		
1st years [n=68]*	93.28	9.89
2nd years [n=62]*	98.44	8.74
3rd years [n=60]*	95.90	10.71
OT faculty [n=13]*	96.62	8.59
non-OT students		
1st years [n=36]*	88.89	13.59
3rd years [n=14]*	89.50	11.13

* indicates difference in respondent numbers from the respondent data given in Table 6:1, this is due to incomplete questionnaires, resulting in missing data.

Figure 6:3 Bar chart showing mean ATDP 'characteristic' sub-scale scores for year groups



Statistical analysis, using Kruskal-Wallis test, indicates a significant difference between the groups (χ^2=20.018, *df*=5, *p*=0.001).

Table 6:8: Results of post hoc analysis of the ATDP 'characteristic' sub-scale scores for the different year groups

comparison	*z*	*p*
OT 1st year v. OT 2nd year	-2.608	0.009*
OT 1st year v. OT 3rd year	-1.003	0.316
OT 1st year v. non-OT 1st year	-1.989	0.047*
OT 1st year v. non-OT 3rd year	-1.375	0.169
OT 1st year v. OT faculty	-0.985	0.325
OT 2nd year v. OT 3rd year	-1.276	0.202
OT 2nd year v. non-OT 1st year	-3.757	<0.001*
OT 2nd year v. non-OT 3rd year	-2.743	0.006*
OT 2nd year v. OT faculty	-0.631	0.528
OT 3rd year v. non-OT 1st year	-2.612	0.009*
OT 3rd year v. non-OT 3rd year	-1.885	0.059
OT 3rd year v. OT faculty	-0.238	0.812
Non-OT 1st year v. non-OT 3rd year	-0.141	0.888
Non-OT 1st year v, OT faculty	-2.085	0.037*
Non-OT 3rd year v. OT faculty	-1.557	0.128

** indicates statistically significant differences*

Post hoc analysis, using Mann-Whitney U tests, indicates that there are significant differences between all OT groups and the 1st year non-OT students. However, only the 2nd year OT students are significantly more positive in their attitudes than the 3rd year non-OT students. The 2nd year OT students are also significantly more positive in their attitudes than the 1st year OT students. These results indicate that all OT students (and OT faculty) are more likely to see disabled people as no different from non-disabled people, in comparison to the 1st year non-OT students. However, as Figure 6:3 indicates, 1st year OT students do not view disabled people as positively as either 3rd year OT students, OT faculty, or, in particular, 2nd year OT students.

Treatment sub-scale

Scores for this sub-scale were calculated in the same way as the previous sub-scale. Items 2, 5, 6, 7, 8, 13, 21, 22, 23, and 28 were identified as the items dealing with attitudes towards the ways that disabled people should be treated. The scores for items 5, 21, 22 and 23 were reversed. The potential range of scores was from 0 – 60, with a high score indicating a positive attitude towards treating disabled people no differently from non-disabled people. The range of scores from the respondent group was 23 – 60, with a mean score of 45.8 (n=252, *sd*=6.07).

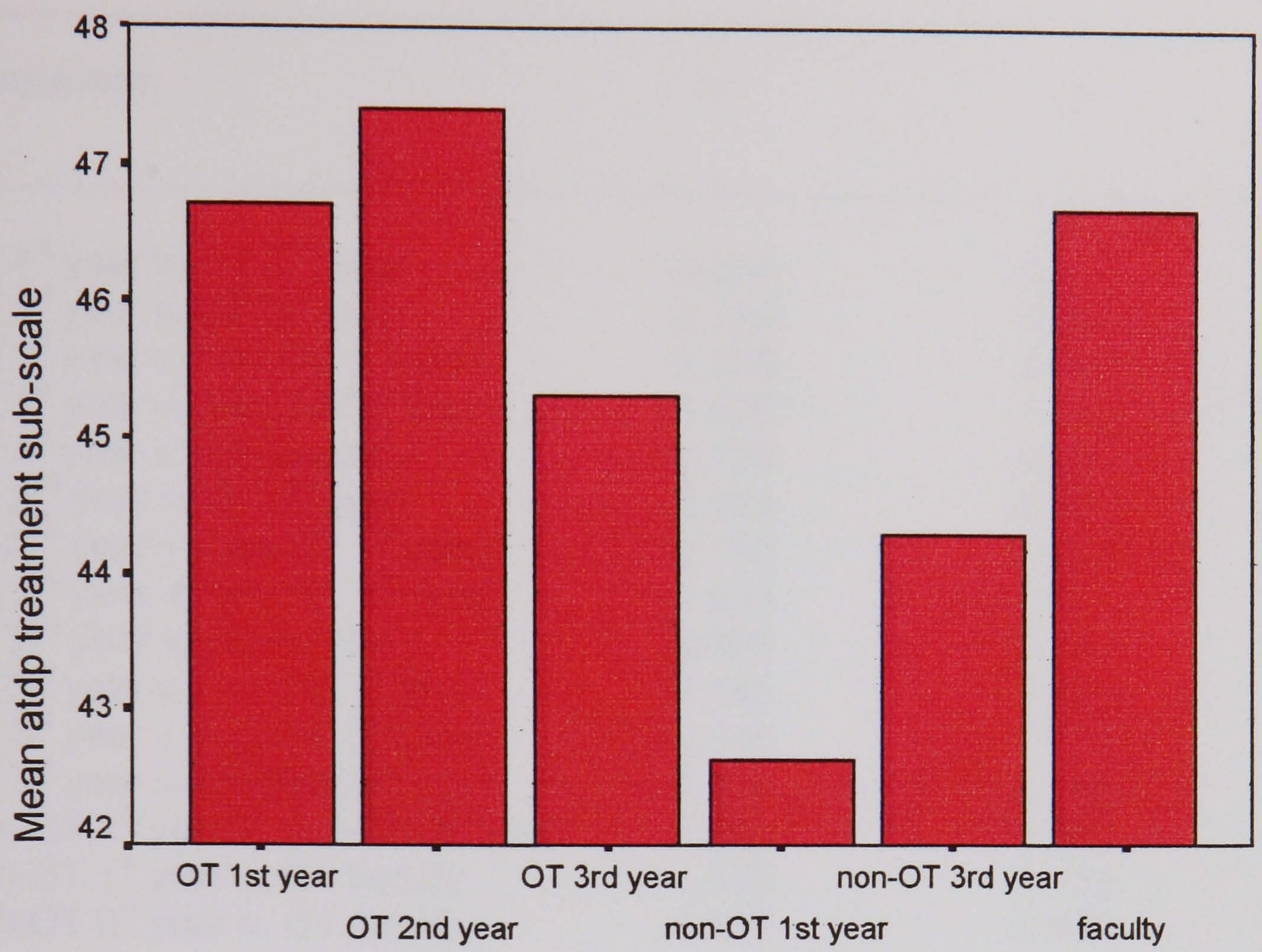
As Table 6:9 and Figure 6:4 show, there are, again, marked differences in the mean scores of the respondent groups, but the pattern of differences is not the same as for the characteristic sub-scale.

Table 6:9 ATDP 'treatment' sub-scale mean scores for the different year groups

respondent group	*mean 'treatment' sub-scale score*	*standard deviation*
OT students		
1st years [n=68]*	46.72	4.82
2nd years [n=60]*	47.42	5.36
3rd years [n=57]*	45.32	5.35
OT faculty [n=13]*	46.69	4.52
non-OT students		
1st years [n=38]*	42.63	8.82
3rd years [n=16]*	44.31	6.36

* indicates difference in respondent numbers from the respondent data given in Table 6:1, this is due to incomplete questionnaires, resulting in missing data.

Figure 6:4 ~~Bar chart showing mean ATDP 'treatment' sub-scale~~ scores for year groups



Statistical analysis, using Kruskal-Wallis test, indicates a significant difference between the groups (χ^2=20.018, *df*=5, *p*=0.001).

Table 6:10: Results of post hoc analysis of the ATDP 'treatment' sub-scale scores for the different year groups

comparison	*z*	*p*
OT 1st year v. OT 2nd year	-0.651	0.515
OT 1st year v. OT 3rd year	-1.769	0.077
OT 1st year v. non-OT 1st year	-2.399	0.016*
OT 1st year v. non-OT 3rd year	-1.576	0.115
OT 1st year v. OT faculty	-0.129	0.867
OT 2nd year v. OT 3rd year	-2.323	0.020*
OT 2nd year v. non-OT 1st year	-2.738	0.006*
OT 2nd year v. non-OT 3rd year	-1.833	0.067
OT 2nd year v. OT faculty	-0.303	0.762
OT 3rd year v. non-OT 1st year	-1.145	0.252
OT 3rd year v. non-OT 3rd year	-0.548	0.584
OT 3rd year v. OT faculty	-1.114	0.265
Non-OT 1st year v. non-OT 3rd year	-0.398	0.690
Non-OT 1st year v, OT faculty	-1.505	0.132
Non-OT 3rd year v. OT faculty	-1.557	0.199

* *indicates statistically significant differences*

Post hoc analysis, using Mann-Whitney U tests, indicates fewer significant differences between OT students and non-OT students. Perhaps the most interesting difference is between the OT 2nd and 3rd year student groups. This indicates that the 3rd year students are more in favour of disabled people being treated differently from non-disabled people. This finding indicates the complexity of oppressive and empowering attitudes. The 3rd year students have experienced three terms of Fieldwork, where disabled people are patients or clients with particular needs. This group of people will be treated differently from non-patients/clients. It might, therefore, not be surprising that this group of students view disabled people differently. However, the complex

issue is whether this different view is oppressive. This theme will be explored further in the concluding chapter of this thesis.

The issue of whether attitudes are oppressive might be explored further by analysing the findings from specific items of the ATDP. Table 6:11 gives a descriptive overview of the analysis of each item.

Table 6:11 Descriptive analysis of individual items of the ATDP

Statistics

	N							
	Valid	Missing	Mean	Median	Mode	Std. Deviation	Minimum	Maximum
ATDP1C	281	2	5.32	6.00	6	.91	1	6
ATDP2T	277	6	4.30	5.00	5	1.30	1	6
ATDP3C	278	5	4.84	5.00	5	1.11	1	6
ATDP4C	275	8	3.74	4.00	3	1.26	1	6
ATDP5T	277	6	3.99	4.00	5	1.33	1	6
ATDP6T	279	4	5.38	6.00	6	.95	1	6
ATDP7T	279	4	5.53	6.00	6	.79	2	6
ATDP8T	277	6	3.76	4.00	3	1.36	1	6
ATDP9C	279	4	5.35	6.00	6	.89	1	6
ATDP10C	279	4	3.92	4.00	3	1.19	1	6
ATDP11C	277	6	5.09	5.00	6	1.07	1	6
ATDP12C	274	9	4.33	5.00	5	1.23	1	6
ATDP13T	278	5	4.97	5.00	6	1.19	1	6
ATDP14C	276	7	4.73	5.00	5	1.13	1	6
ATDP15C	277	6	5.18	5.00	6	.99	2	6
ATDP16C	274	9	3.92	4.00	5	1.44	1	6
ATDP17C	271	12	4.05	4.00	4	1.24	1	6
ATDP18C	267	16	5.12	6.00	6	1.14	1	6
ATDP19C	271	12	3.79	4.00	3[a]	1.26	1	6
ATDP20C	270	13	4.98	5.00	5	1.02	1	6
ATDP21T	273	10	3.99	4.00	4	1.26	1	6
ATDP22T	274	9	4.35	5.00	5	1.28	1	6
ATDP23T	277	6	4.95	5.00	6	1.37	1	6
ATDP24C	277	6	5.06	5.00	5	1.05	1	6
ATDP25C	275	8	4.35	4.00	5	1.18	1	6
ATDP26C	272	11	4.49	5.00	5	1.23	1	6
ATDP27C	274	9	5.63	6.00	6	.80	1	6
ATDP28T	264	19	4.60	5.00	6	1.54	1	6
ATDP29C	275	8	4.93	5.00	6	1.29	1	6
ATDP30C	274	9	5.50	6.00	6	.95	1	6

a. Multiple modes exist. The smallest value is shown.

Based on the descriptive analysis, items 2, 5, 8, 16, 23, and 28 are worth further investigation because of the relatively high standard deviations (1.30+) and/or discrepancy between the various measures of central tendency. Statistical analysis, using Kruskal-Wallis test, indicates statistically significant differences between the respondent groups for items 3, 4, 10, 14, 15, 20, 23, 26 and 28. These items are also worthy of further investigation.

Table 6:12 gives an overview of the statistical analysis of the individual items, using Kruskal-Wallis tests.

Table 6:12 Analysis of individual ATDP items, indicating differences between respondent groups

item	χ^2	*df*	*p*
1	8.138	5	0.149
2	3.126	5	0.681
3	15.412	5	0.009*
4	13.503	5	0.019*
5	7.532	5	0.184
6	10.038	5	0.074
7	3.903	5	0.563
8	2.564	5	0.767
9	4.517	5	0.478
10	17.464	5	0.004*
11	3.664	5	0.599
12	4.083	5	0.537
13	4.695	5	0.456
14	19.138	5	0.002*
15	15.723	5	0.008*
16	8.964	5	0.111
17	4.439	5	0.488
18	9.115	5	0.105
19	1.744	5	0.883
20	17.944	5	0.003*
21	5.422	5	0.367
22	4.015	5	0.547
23	12.148	5	0.033*
24	6.543	5	0.257
25	4.292	5	0.508
26	22.076	5	0.001*
27	8.649	5	0.124
28	11.219	5	0.047*
29	4.312	5	0.505
30	8.641	5	0.124

** indicates significant differences*

Analysis of items:

2 - Disabled people should not have to compete for jobs with physically normal people;

5 - We should expect just as much from disabled as from non-disabled persons;

8 - Most non-disabled people would not want to marry anyone who is physically disabled;

and

16 - Severely disabled people probably worry more about their health than those who have minor disabilities;

indicates no significant differences between the groups. Responses for these items were evenly spread across the various responses. Analysis, using Mann-Whitney U tests, of items:

3 - Disabled people are more emotional than other people;

4 - Most disabled people are more self-conscious than other people;

10 - Disabled people are usually more sensitive than other people;

14 - Disabled people are usually sociable;

15 - Disabled people usually are not as conscientious as physically normal people;

20 - Most disabled persons resent physically normal people;

23 - It would be best if disabled persons would live and work with non-disabled persons;

26 - Most disabled persons want more affection and praise than other people;

and

28 - Most disabled people are different from non-disabled people;

indicates that where there were significant differences, these tended to be between the 1st year OT students and the other OT groups; between 2nd year OT students and both non-OT groups; and, between 3rd year OT students and 1st year non-OT students. Table 6:13 gives an overview of this analysis.

Table 6:13 Analysis of specific ATDP items, by year group

ATDP item *comparison*	*z*	*P*
3		
1st year OT v. 2nd year OT	-3.018	0.003
1st year OT v. 3rd Year OT	-2.100	0.036
1st year OT v. OT faculty	-2.820	0.005
2nd year OT v. 1st year non-OT	-2.075	0.038
4		
1st year OT v. 2nd year OT	-2.582	0.010
2nd year OT v. 1st year non-OT	-2.852	0.004
3rd year OT v. 1st year non-OT	-2.108	0.035
10		
1st year OT v. 2nd year OT	-2.621	0.009
1st year OT v. 3rd year OT	-3.310	0.002
2nd year OT v. 1st year non-OT	-2.146	0.032
2nd year OT v. 3rd year non-OT	-2.466	0.014
3rd year v. 1st year non-OT	-2.435	0.015
3rd year OT v. 3rd year non-OT	-2.870	0.004
14		
1st year OT v. 1st year non-OT	-2.313	0.021
1st year OT v. 3rd year non-OT	-2.202	0.028
1st year OT v. OT faculty	-2.505	0.012
2nd year OT v. 1st year non-OT	-2.359	0.018
2nd year OT v. 3rd year non-OT	-2.177	0.030
2nd year OT v. OT faculty	-2.586	0.010
3rd year OT v. 1st year non-OT	-2.734	0.006
3rd year OT v. 3rd year non-OT	-2.613	0.009
3rd year OT v. OT faculty	-2.782	0.005
15		
1st year OT v. 2nd year OT	-2.832	0.005
1st year OT v. 3rd year non-OT	-2.279	0.023

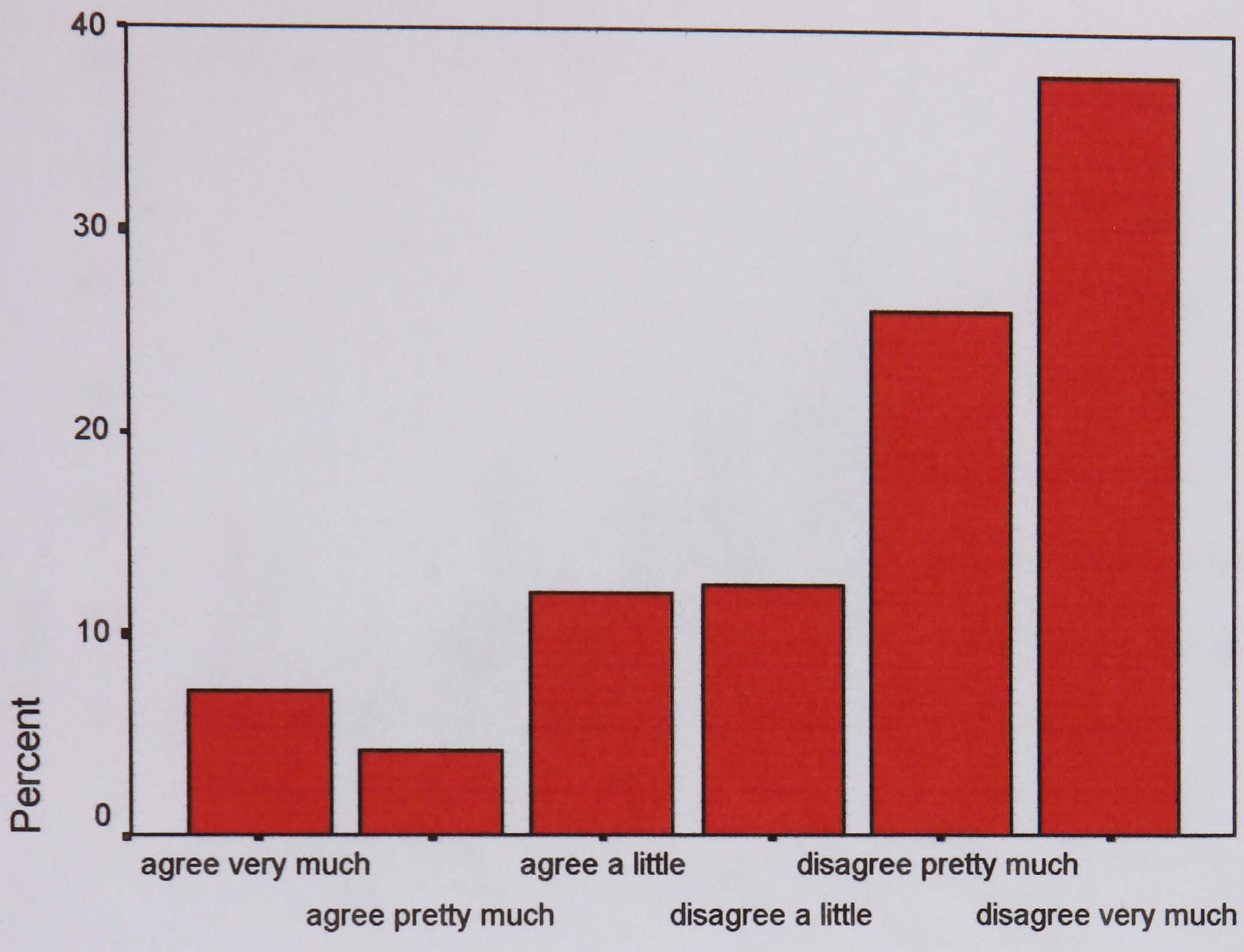
1st year OT v. OT faculty	-2.989	0.003
3rd year OT v. OT faculty	-2.149	0.032
1st year non-OT v. OT faculty	-2.222	0.026
20		
1st year OT v. 2nd year OT	-2.405	0.016
1st year OT v. 3rd year OT	-2.029	0.042
1st year OT v. 3rd year non-OT	-2.367	0.018
2nd year OT v. 3rd year non-OT	-3.392	0.001
3rd year OT v. 3rd year non-OT	-3.249	0.001
1st year non-OT v. 3rd year non-OT	-2.560	0.010
23		
1st year OT v. 1st year non-OT	-3.034	0.002
2nd year OT v. 1st year non-OT	-2.666	0.008
3rd year OT v. 1st year non-OT	-1.986	0.047
1st year non-OT v. OT faculty	-1.956	0.051
26		
1st year OT v. 2nd year OT	-2.916	0.004
1st year OT v. 3rd year OT	-3.282	0.001
1st year OT v. OT faculty	-2.436	0.015
2nd year OT v. 1st year non-OT	-2.957	0.003
3rd year OT v. 1st year non-OT	-3.216	0.001
1st year non-OT v. OT faculty	-2.398	0.016
28		
1st year OT v. 2nd year OT	-1.751	0.080
2nd year OT v. 3rd year OT	-2.416	0.016
2nd year OT v. 1st year non-OT	-2.710	0.007
2nd year OT v. 3rd year non-OT	-2.297	0.022

The fact that the 1st year OT student group are often significantly less positive in their attitudes than the other OT groups might indicate that attitude change was part of a maturation process. However, it must be maturation as an OT, because there do not appear to be similar differences between the 1st and 3rd year non-OT groups. In fact, for one item (Most disabled persons resent physically normal people), it is the 3rd year non-OT group who hold the most negative attitudes.

It is interesting that for item 28 (Most disabled people are different from non-disabled people) the significant differences are between the 2nd year OT group and all of the other student groups. In some ways this statement is the key item of the ATDP. It is certainly the most complex in terms of what a positive attitude might be. The assumption of the ATDP is that disabled people are no different from non-disabled people. An empowering, positive, attitude would also be that disabled people were not different from non-disabled people however, disabled activists and writers (e.g. Mace, 1995; Corbett, 1996; Morris, 1989, 1996) have proposed the idea of disabled 'pride' and celebrating different-ness. OT students, especially in the 2nd year module 1528: Practice in Partnership, would certainly have been exposed to the complexity of these ideas. However, by the end of their studies, OT students would also have spent 1,000 hours on Fieldwork where disabled people are patients/clients and, by their very nature, dependent and different.

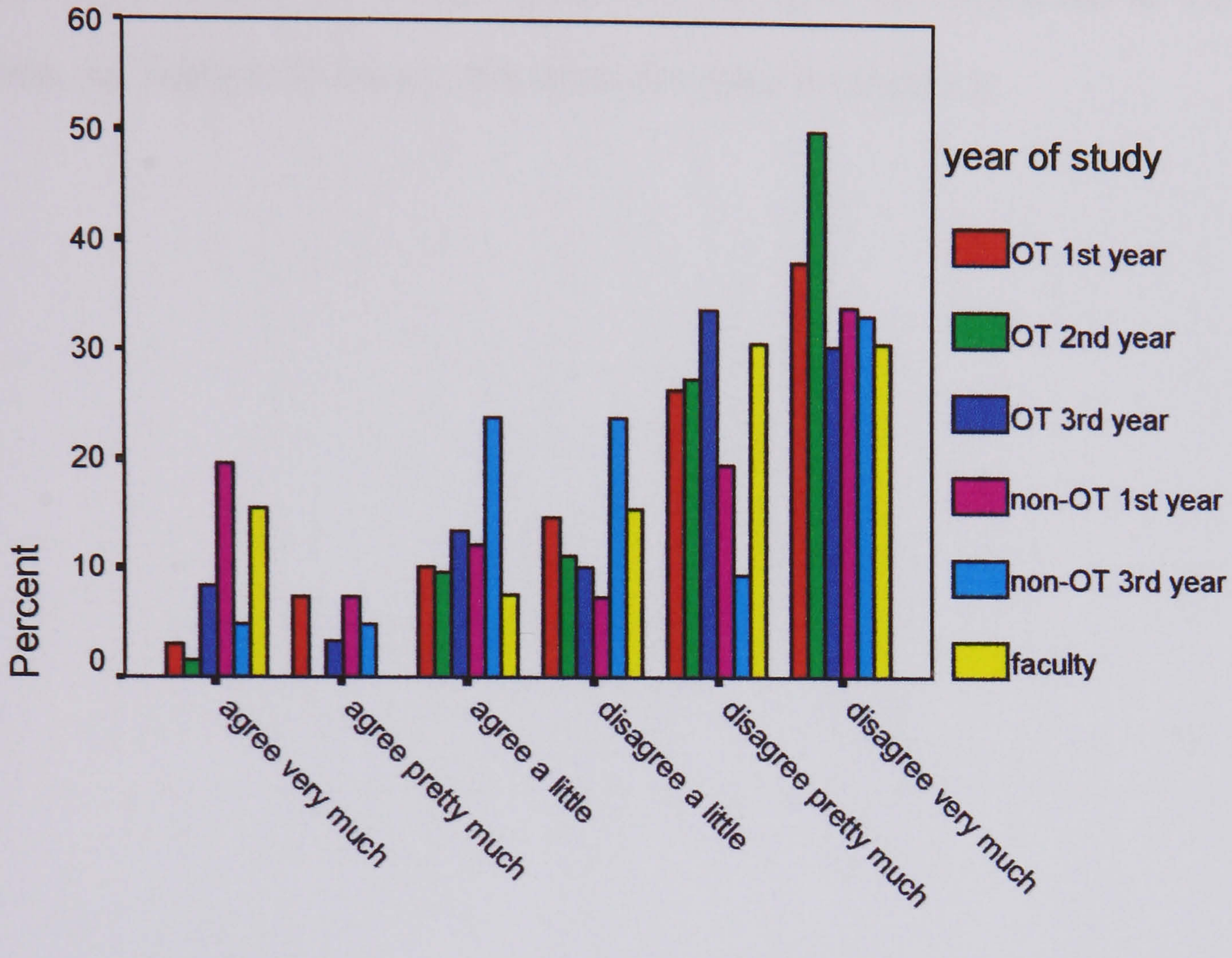
The majority of respondents (76.5%) disagreed with the statement (Most disabled people are different from non-disabled people), as Figure 6:5 shows.

Figure 6:5 Graph showing responses to ATDP item 28



However, as Figure 6:6 (and the statistical analysis) shows, the distribution of responses between the various year groups is more complex.

Figure 6:6 Graph showing distribution of responses to ATDP item 28 by year groups



Whilst the non-OT students hold the least positive attitudes, it is interesting to note the responses of the OT faculty. 23.1% of the OT faculty group see disabled people as different from non-disabled people. Whilst this is only 3 respondents, it is an interesting finding, given that the OT faculty act as role models during the professional socialisation of the OT students. This finding highlights the need to explore the attitudes of qualified and practising OTs.

Having analysed the responses for the ATDP as a whole and responses to specific items, it would seem appropriate to explore the validity and

limitations of the ATDP as a research tool. Yuker and Block (1986) have argued that the ATDP is an uni-dimensional measure of attitudes. If this is the case there should be strong correlations between the responses to the 30 items. As Table 6:14 shows, this is not the case in this study.

Table 6:14 Correlation Matrix for ATDP

ATDP item	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1		.27	.36	.35	.23	.39	.39	.11	.31	.25	.34	.17	.34	.26	.28	.17	.29	.34	.13	.27	.13	.21
2			.24	.22	.29	.16	.16	.01	.16	.16	.20	.09	.27	.07	.21	.15	.12	.19	-.02	.20	.32	.06
3				.44	.26	.32	.32	.06	.30	.40	.31	.18	.23	.08	.35	.23	.24	.36	.02	.19	.09	.14
4					.24	.18	.26	.15	.20	.52	.17	.15	.26	.19	.17	.27	.21	.23	.11	.27	.11	.12
5						.15	.22	.05	.24	.18	.26	.15	.22	.20	.25	.23	.19	.25	.09	.13	.29	.17
6							.46	.07	.46	.17	.29	.24	.25	.24	.25	.10	.27	.38	-.02	.18	.20	.21
7								.22	.41	.15	.35	.14	.27	.19	.38	.18	.24	.43	.05	.19	.14	.18
8									.21	.13	.19	.17	.11	.06	.05	.04	.26	.20	.01	.15	.04	.08
9										.09	.33	.26	.30	.29	.26	.12	.28	.42	.12	.25	.20	.15
10											.15	.18	.24	.17	.14	.24	.17	.16	-.01	.22	.13	.11
11												.14	.30	.13	.33	.27	.26	.39	.02	.26	.16	.28
12													.18	.08	.23	.08	.43	.16	.18	.15	.21	.22
13														.09	.29	.16	.20	.31	-.01	.27	.12	.08
14															.18	.11	.15	.25	.23	.27	.22	.14
15																.16	.18	.37	.03	.17	.25	.19
16																	.04	.24	.04	.21	.13	.22
17																		.31	.23	.23	.19	.27
18																			.05	.32	.15	.16
19																				.17	.09	.14
20																					.16	.23
21																						.29
22																						
23																						
24																						
25																						
26																						
27																						
28																						
29																						
30																						
ATDP total																						

ATDP item	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*	*total*
1	.24	.29	.20	.38	.32	.31	.28	.41	.54
2	.15	.14	.12	.26	.17	.17	.13	.23	.40
3	.19	.20	.19	.44	.22	.23	.22	.33	.52
4	.06	.14	.28	.23	.11	.19	.07	.25	.52
5	.20	.29	.26	.31	.21	.20	.20	.24	.49
6	.21	.29	.07	.31	.28	.29	.39	.39	.44
7	.20	.24	.13	.31	.32	.27	.25	.41	.49
8	-.06	.06	.21	.11	.14	.05	.06	.17	.26
9	.20	.35	.27	.23	.31	.29	.29	.42	.49
10	.03	.10	.18	.31	.06	.16	.15	.11	.43
11	.23	.29	.24	.37	.32	.23	.26	.34	.49
12	-.01	.13	.33	.21	.08	.08	.17	.17	.42
13	.13	.18	.12	.26	.27	.22	.31	.20	.40
14	.24	.24	.16	.11	.05	.14	.31	.20	.42
15	.25	.21	.08	.28	.28	.22	.23	.34	.43
16	.13	.19	.15	.38	.12	.25	.14	.26	.39
17	-.03	.21	.35	.29	.21	.09	.23	.42	.47
18	.08	.26	.16	.35	.32	.21	.36	.43	.54
19	.05	.06	.21	-.01	.04	-.06	.12	.09	.26
20	.14	.17	.24	.31	.17	.26	.21	.31	.49
21	.23	.25	.17	.24	.14	.18	.22	.20	.46
22	.22	.26	.21	.24	.19	.21	.23	.26	.45
23		.34	.12	.18	.17	.15	.15	.18	.33
24			.43	.25	.21	.17	.31	.27	.47
25				.18	.06	.09	.17	.22	.51
26					.26	.32	.31	.35	.54
27						.29	.19	.36	.37
28							.26	.28	.44
29								.25	.44
30									.54
ATDP total									

These low correlations imply that the ATDP is measuring a number of different factors. This is supported by factor analysis.

Table 6:15 Results of a factor analysis of the ATDP data

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Factor 8	Factor 9
1						.514			
2								.768	
3		.603							
4		.781							
5									
6									
7	.664								
8									.694
9									
10		.778							
11									
12				.800					
13						.620			
14							.780		
15	.711								
16									
17				.675					
18	.685								
19							.589		
20									
21								.560	
22					.502				
23			.670						
24			.695						
25			.603						
26									
27	.539								
28					.694				
29									
30	.582								

Extraction Method: Principal Component Analysis
Rotation Method: Varimax with Kaiser Normalisation

The Eigenvalues and percentage of variance for each of the factors are:

1. 6.811, 22.704%
2. 1.806, 6.021%
3. 1.666, 5.552%

4. 1.525, 5.083%

5. 1.296, 4.321%

6. 1.217, 4.058%

7. 1.171, 3.902%

8. 1.090, 3.633%

9. 1.032, 3.461%.

Of the nine factors identified, only three factors appeared to be meaningful, these were factors 2, 4 and 8. The remaining six factors contained items which did not appear to fit together logically or meaningfully.

Factor 2, which accounted for only 6.02% of the common variance, was labelled 'emotional strength' (items 4, 10 & 3, in order of loading value). This factor reflects the respondents' perception that disabled people are, or are not, emotionally secure. Factor 4 (items 12 & 17), which accounts for 5.08% of the variance, was labelled 'sense of self-worth' and reflects perceptions of disabled people seeing themselves as equals in society (not to be confused whether respondents view disabled people as equals). The final meaningful factor, factor 8 (items 2 & 21) accounting for 3.63% of variance, was named 'competitive equality'. This factor reflects the respondent's perception of whether disabled people should be expected to compete with non-disabled people.

It proved impossible to name the remaining six factors, as they held no logical or coherent meaning. Factor 1, accounting for 22.7% of variance (items 15, 18, 7, 30 & 27), appeared to represent perceptions of the worth, or value, of

disabled people in society, if items 30 and 27 were excluded. The other factors contained items as diverse as 'disabled people are unfriendly' and 'disabled people should take a more severe driving test' (factor 6), which did not appear to be meaningfully connected.

It was thought that the non-OT data might have affected the rigour of the factor analysis, because of the gender differences between the OT and non-OT groups, as previous research (Yuker and Block, 1986) had found that gender might be a confounding variable. The non-OT group also had more negative ATDP scores than the OT group. A second factor analysis was, therefore, carried out on the OT ATDP data alone. The results of this factor analysis were, however, no different from the analysis of the total data.

How these factors compare with those found by other researchers (e.g. Livneh, 1982) will be discussed in the final chapter. The factorial ambiguity and multi-dimensionality of the ATDP will also be discussed in the final chapter.

Social distance

The social distance scale used in the main questionnaire asked respondents to indicate, using the following scale:

definitely;

maybe;

never;

whether they would be prepared to engage in a variety of social relationships with disabled people. Descriptive analysis for each of the items will now be presented.

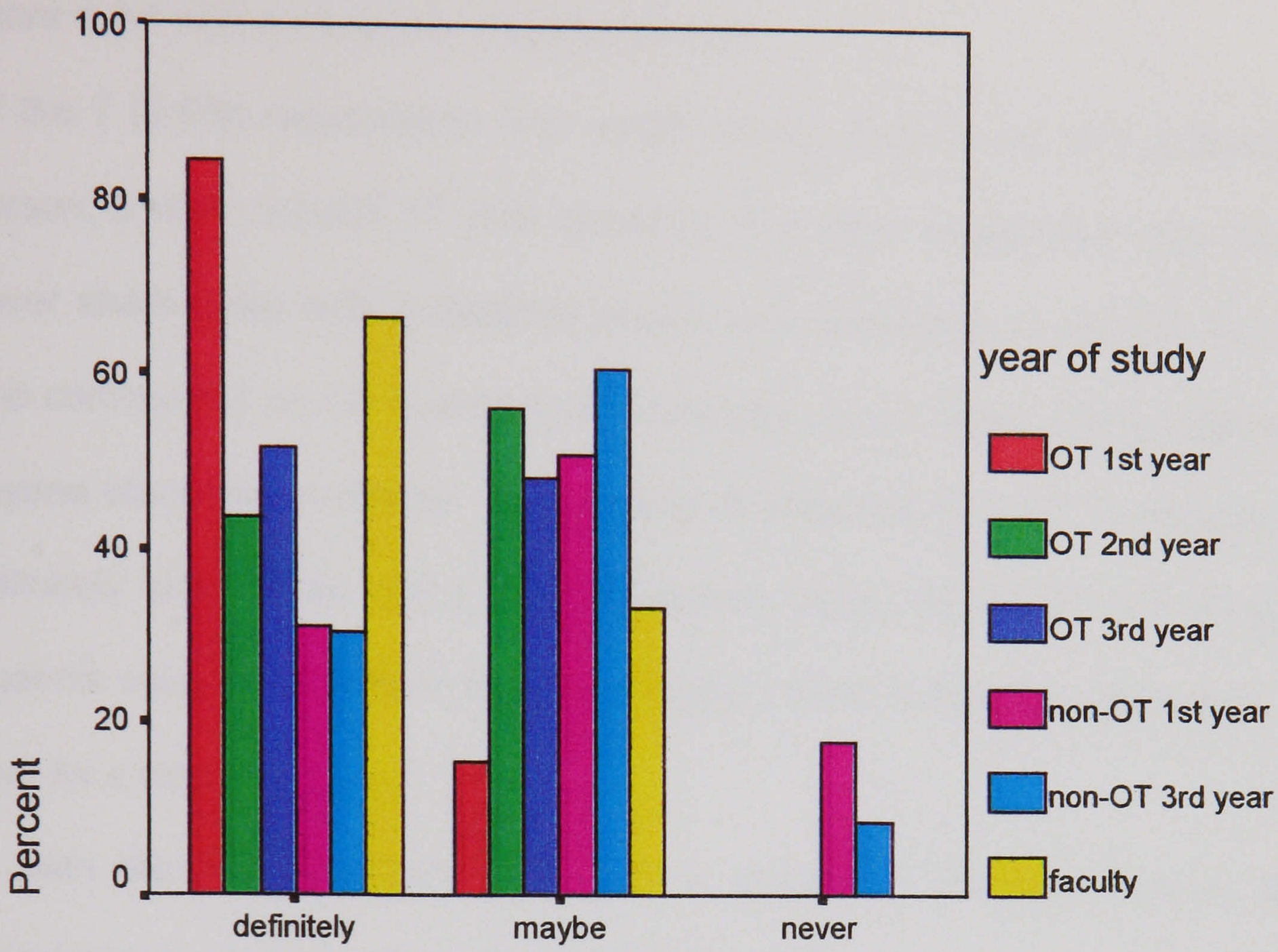
work with a physically disabled person

No respondent stated that they would 'never' work with a disabled person and only 18 (6.4%) responded 'maybe'. Of this 6.4% the majority (11) were non-OT 1st year students with some non-OT 3rd year students (4), OT 2nd years (1), OT 3rd years (1), and OT faculty (1).

go out with a physically disabled person

The only respondents to say they would 'never' go out with a disabled person were 10 (3.6%) non-OT students (8 non-OT 1st years). Of the remainder, 151 (53.7%) responded that they would 'definitely' go out with a disabled person and 120 (42.7%) responded 'maybe'. Figure 6:7 gives an overview of the responses for the different year groups.

Figure 6:7: Bar chart showing the distribution of responses for 'go out with a physically disabled person'



go out with a physically disabled person

It should be noted, from Figure 6:7, that whilst the 1st year OT students and the OT faculty are all fairly definite that they would go out with a disabled person, the 2nd and 3rd year OT students are much more equivocal in their responses. This is interesting in view of the more positive ATDP scores of the 2nd and 3rd year OT students in comparison to the 1st year OT students. It could be that by the time students are in their 2nd and 3rd years of study they may be more likely to be involved in relationships and so do not see 'definitely' as an appropriate option. If, however, this were the case one would expect similar responses from the OT faculty, but this is not the case. Thus

we are beginning to see that positive attitudes do not always equate with positive behaviour.

share a flat with a physically disabled person

Of the 7 (2.5%) respondents who would 'never' share a flat with a disabled person, 6 were non-OT 1st year students. The other respondent who would never share a flat with a disabled person was a member of the OT faculty, who commented on the questionnaire that s/he would never share a flat with anyone other than a partner. The majority of respondents (196, 69.8%) would 'definitely' share a flat with a disabled person. Again the OT 2nd and 3rd year students were more likely to respond 'maybe' (19:45 & 18:46 respectively).

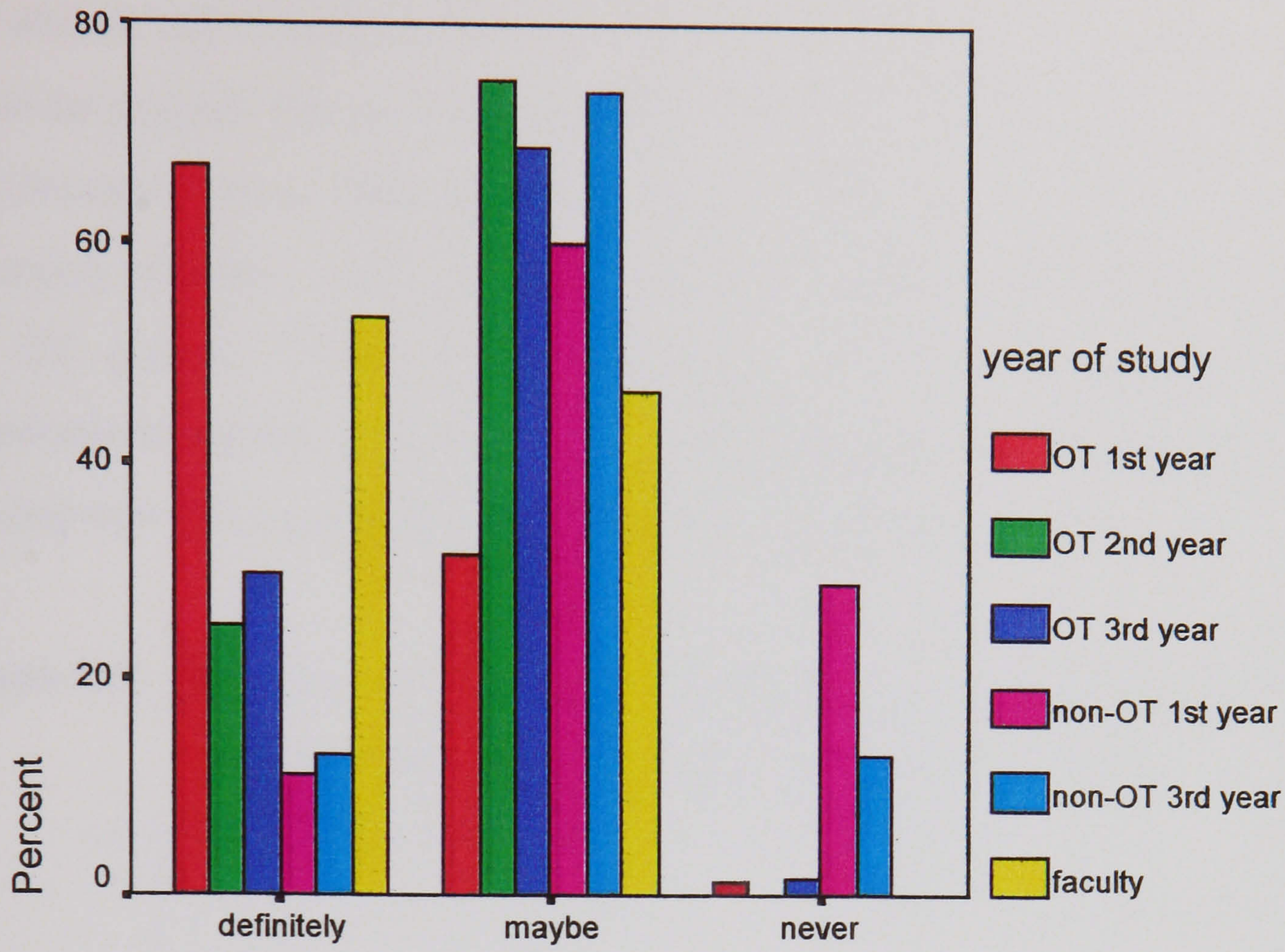
work for a disabled person

As with the first question, work *with* a physically disabled person, the overwhelming majority responded 'definitely' (253, 90.4%). However, unlike the first question, 3 non-OT 1st year students responded 'never' to this question.

marry a physically disabled person

The modal response for this question was 'maybe' with 185 (58.7%) respondents answering this way. Figure 6:8 gives an overview of the responses of the different year groups.

Figure 6:8: Bar chart showing the distribution of responses for 'marry a physically disabled person'



marry a physically disabled person

As with 'go out with a physically disabled person', we have the higher likelihood of a 'maybe' response, not only from the non-OT groups, but also from the OT 2nd and 3rd year groups. Again, this indicates less positive behavioural aspects to the attitudes of these groups.

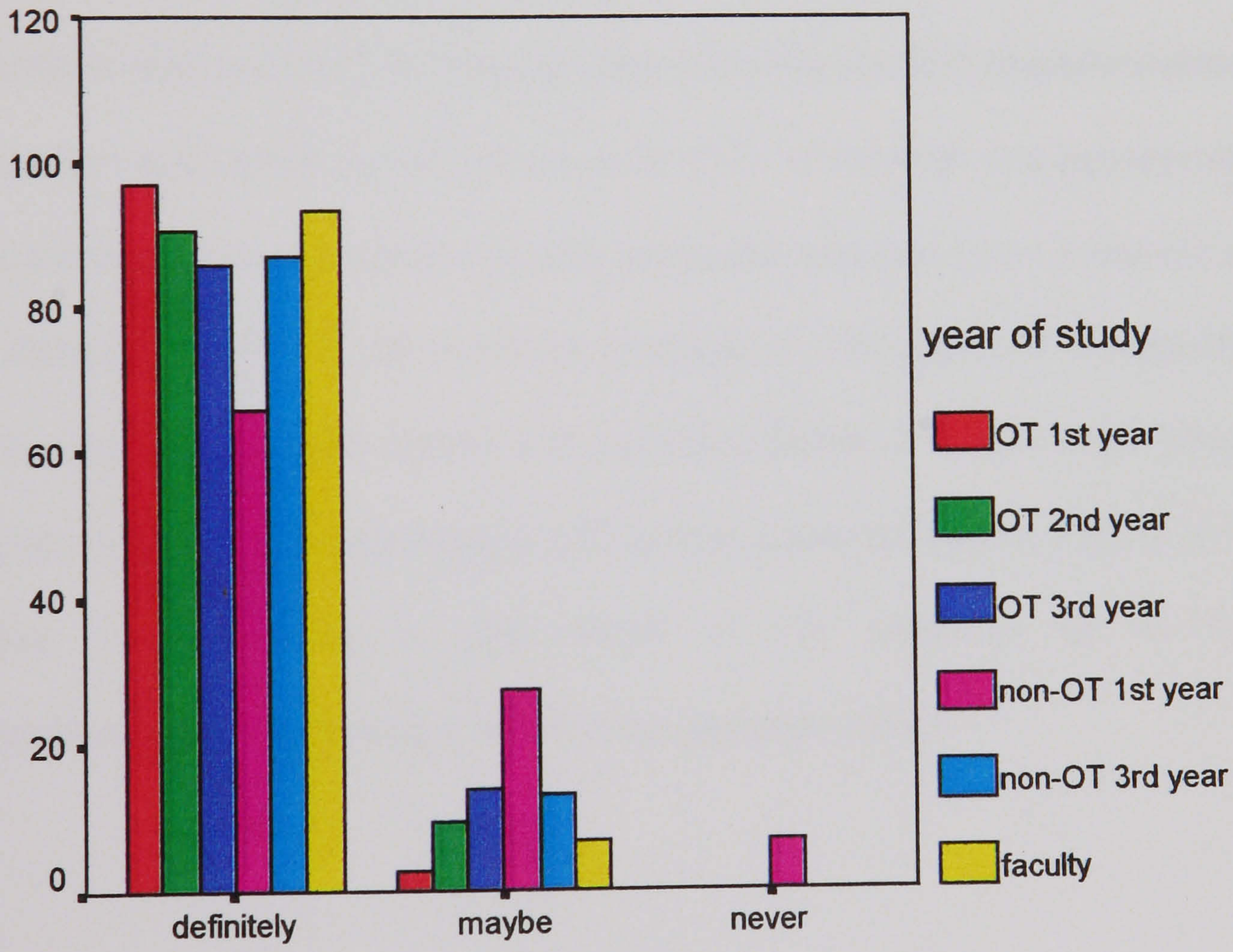
vote for a physically disabled person

Although predominantly positive, respondents were less likely to 'definitely' vote for a disabled person (239, 85.1%) than they were to work with or for a disabled person. The 4 (1.4%) respondents who would 'never' vote for a disabled person were all non-OT 1st year students. The 'maybe' responses were divided amongst all the groups, with the OT 2nd and 3rd year and the non-OT 1st year students proportionally higher (8:56, 8:56 & 17:24 respectively).

let a friend or family member marry a disabled person

Again a mostly 'definitely' response (244, 87.1%) was found but, as Figure 6:9 shows, with surprising numbers of 'maybe' amongst the OT groups. It could be argued, that as each individual should be viewed, by the OTs, as self-directed (Yerxa, 1983, DePoy & Merrill, 1988) and having the right to autonomy (Polatjko, 1992), there should be no 'maybe' responses for any of the OT groups. These 'maybe' responses could imply that some OT respondents appear to be viewing disabled people negatively and also viewing their friends and families as less than autonomous beings.

Figure 6:9: Bar chart showing the distribution of responses for 'let a friend or family member marry a disabled person'



spend leisure time with a physically disabled person

The responses to this question were overwhelmingly positive with 257 (91.8%) respondents saying they would 'definitely' spend leisure time with a disabled person. Only 1 (0.4%) person, a non-OT 1st year student, responded 'never'. The 'maybe' responses (22, 7.9%) were mostly from non-OT 1st years (13) with some OT 2nd (3) and 3rd (4) year students.

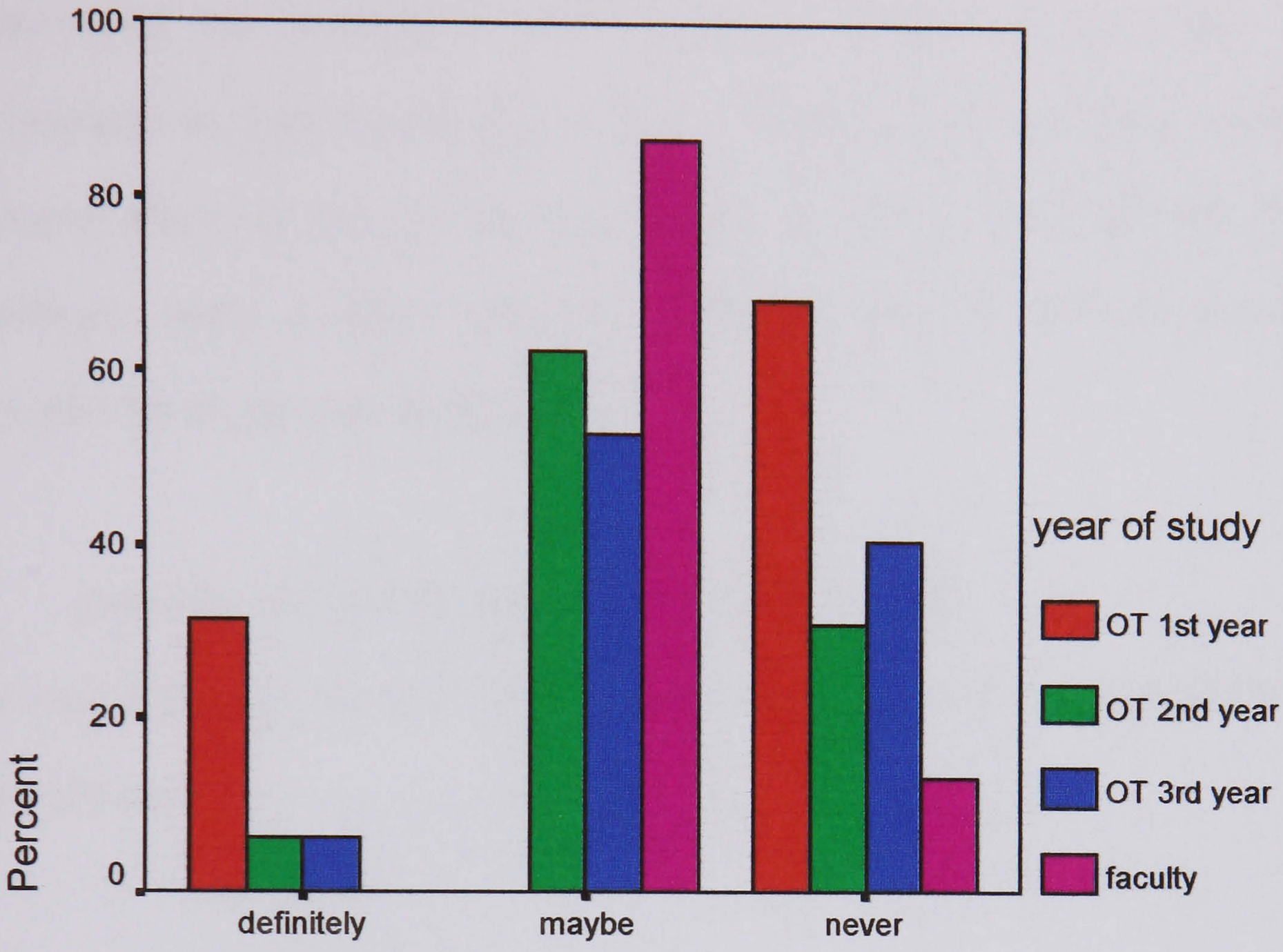
live near physically disabled people

This produced the most positive response of this section, with 270 (96.1%) responding that they would 'definitely' live near disabled people. The 'never' (1, 0.4%) and 'maybe' (10, 3.6%) responses were all from non-OT students.

go out with someone you have treated

This question was omitted, as inappropriate, from the non-OT questionnaires. This question addressed an ethical issue for OTs, of whether it is appropriate to have a more intimate relationship with someone who has been a patient or client. Although the OT code of ethics (College of Occupational Therapists, 1996) is clear about relationships with patients/clients, it is less clear about the appropriateness of relationships with former patients/ clients. Figure 6:10 highlights the confusion in the minds of OT students as to the appropriateness of relationships with former patients/clients.

Figure 6:10: Bar chart showing the distribution of responses to 'go out with someone you have treated'



go out with someone you had treated

Overall the results of these social distance items indicate positive attitudes towards disabled people. The majority of respondents indicated a willingness to associate with disabled people in a variety of settings. The non-OT respondents tended to have the least positive responses. However, there were also, somewhat surprisingly, negative and equivocal responses from some of the OT respondents. These included 3 OT respondents who would 'never' 'work with a disabled person' and the relatively high number of 'maybe' responses to 'go out with', 'share a flat with', 'marry', and 'let a friend or family member marry a disabled person'. These responses are less than wholly positive and, therefore, indicate that professionally positive attitudes towards

disabled people might not always be linked to personally positive attitudes although it might be that the 'maybe' response is the more realistic for those items where the relationship with a disabled person is close and the commitment to the disabled person is, therefore, higher. This realistic response might, in fact, be more empowering, as it is more honest. The, apparently, more positive 'definitely' response may, in fact, be a more patronising and oppressive response.

Suitability for training as an occupational therapist

The next section of the main questionnaire asked respondents to indicate on a 4-point scale of:

unsuitable;

probably unsuitable;

probably suitable;

suitable;

whether individuals with particular disabling conditions or impairments would be suitable candidates for training as OTs.

The mean scores for each item was calculated and Table 6:16 shows the results in terms of a preferred order of suitability to train as an OT. It should be noted that the lowest score, a mean of 1.97 for 'someone with a history of schizophrenia' was based on an 81% response of 'unsuitable' or 'probably unsuitable' and that at the other end of the scale the highest score, a mean of 3.75 for 'someone with controlled diabetes', was based on an 78.3% response of 'suitable'. These results clearly indicate that the majority of

respondents did feel that individuals with some impairments or disabling conditions might be more or less suitable to train as OTs.

Table 6:16: Overall mean scores of suitability to train as an OT

impairment	*mean suitability score [mode]*	*sd*
someone with a history of schizophrenia	1.97 *[2]*	.80
someone who is blind	2.44 *[2]*	.92
someone with a history of depression	2.52 *[2]*	.83
someone who is a wheelchair user	2.94 *[3]*	.79
someone who is 6 stone overweight	2.95 *[3]*	.87
someone who is deaf	3.03 *[3]*	.86
someone with a history of eating problems	3.04 *[3]*	.76
someone who has severe asthma	3.05 *[3]*	.83
someone who is partially sighted	3.18 *[3]*	.72
someone with an above knee amputation	3.29 *[4]*	.76
someone with controlled epilepsy	3.42 *[4]*	.72
someone who is partially hearing	3.51 *[4]*	.63
someone who is 4'8" tall	3.59 *[4]*	.65
someone with a facial deformity	3.64 *[4]*	.60
someone with controlled diabetes	3.75 *[4]*	.51

It should also be noted that as the suitability score increases, so the standard deviation decreases, indicating a greater level of agreement between the

respondents about those conditions or impairments which were deemed more acceptable to train as an OT.

If we take a mean score of less than 3 as indicating that someone with that particular impairment or condition is unsuitable to train as an OT, based on the rating scale of 3+ indicating someone as 'suitable' or 'probably suitable' to train as an OT, then only 5 items fulfil this criteria. The impairments or conditions seen as unsuitable to train as an OT are:

someone with a history of schizophrenia;

someone who is blind;

someone with a history of depression;

someone who is a wheelchair user;

someone who is 6 stone overweight.

The remaining 10 impairments and conditions were deemed suitable to train as OTs.

French (1987), in her study of physiotherapists' attitudes towards the recruitment of disabled people, identified impairments and conditions which were suitable or unsuitable by calculating the percentage of 'suitable' and 'probably suitable' for the positive responses and 'unsuitable' and 'probably unsuitable' for the negative responses. Tables 6:17 compares French's (1987) physiotherapy results with the current OT results.

Table 6:17: Impairments and disabling conditions considered to be 'suitable' or 'probably suitable' for OT training, a comparison with physiotherapy

impairment	*OT* %	*physio* % [rank]
someone with a history of schizophrenia	19.9	19 [4]
someone who is blind	44.0	83 [12]
someone with a history of depression	46.2	67 [10]
someone who is a wheelchair user	72.5	9 [1]
someone who is 6 stone overweight	70.2	11 [2]
someone who is deaf	74.1	33 [5]
someone with a history of eating problems	77.3	n/a
someone who has severe asthma	74.3	16 [3]
someone who is partially sighted	84.5	92 [13]
someone with an above knee amputation	87.5	48 [6]
someone with controlled epilepsy	89.1	70 [11]
someone who is partially hearing	94.6	61 [8]
someone who is 4'8" tall	93.1	63 [9]
someone with a facial deformity	94.9	60 [7]
someone with controlled diabetes	98.8	95 [14]

NB: It should be noted that French (1987) included a 'don't know' category in her study. She also included other conditions in her list (e.g. physically inactive, recurrent dislocation of patella) which were deemed inappropriate to this study.

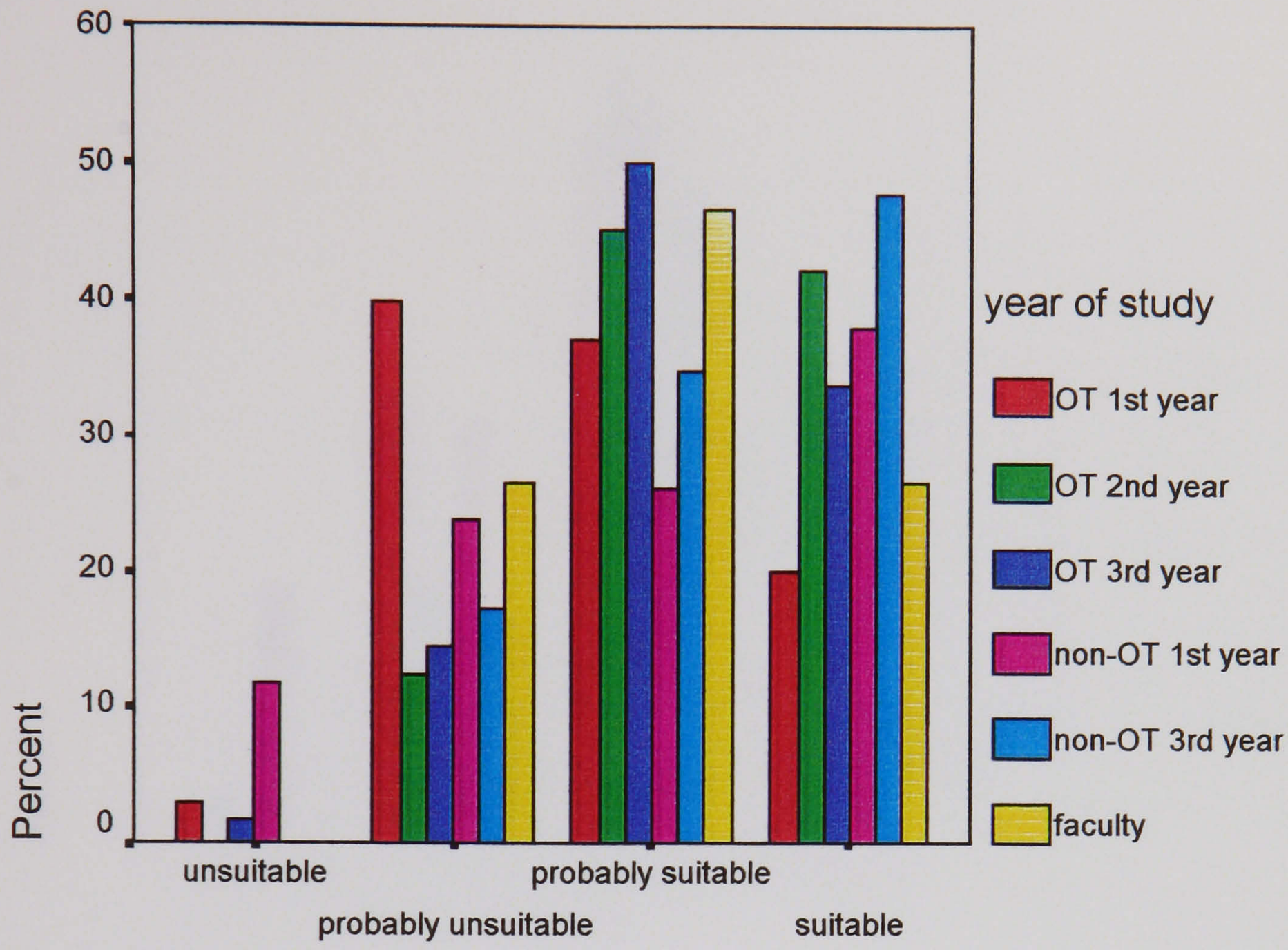
It is interesting to note that people with visual impairments or a history of mental health problems are seen as the least suited for training as OTs, whilst people with conditions which might impair mobility are seen as least appropriate to train as physiotherapists.

Analysis of the responses of OT and non-OT students for the individual conditions reveals that, for the most part, the results for the different groups of respondents are similar. However, there are a number of differences, which are worth noting.

someone with severe asthma

As Figure 6:11 shows responses to this item were very diverse with more negative responses from the non-OT 1st year students (unsuitable: 12%; probably unsuitable: 24%; probably suitable: 26%; suitable: 38%) and the 1st year OT students (unsuitable: 3%; probably unsuitable: 40%; probably suitable: 37%; suitable: 20%) in comparison with the overall results (unsuitable: 3%; probably unsuitable: 23%; probably suitable: 41%; suitable 34%), with more positive responses from the 2nd year OT students (suitable: 42%) and the non-OT 3rd year students (suitable: 48%).

Figure 6:11: Bar chart to illustrate frequency of responses by year of study for suitability of 'someone with severe asthma' for OT training

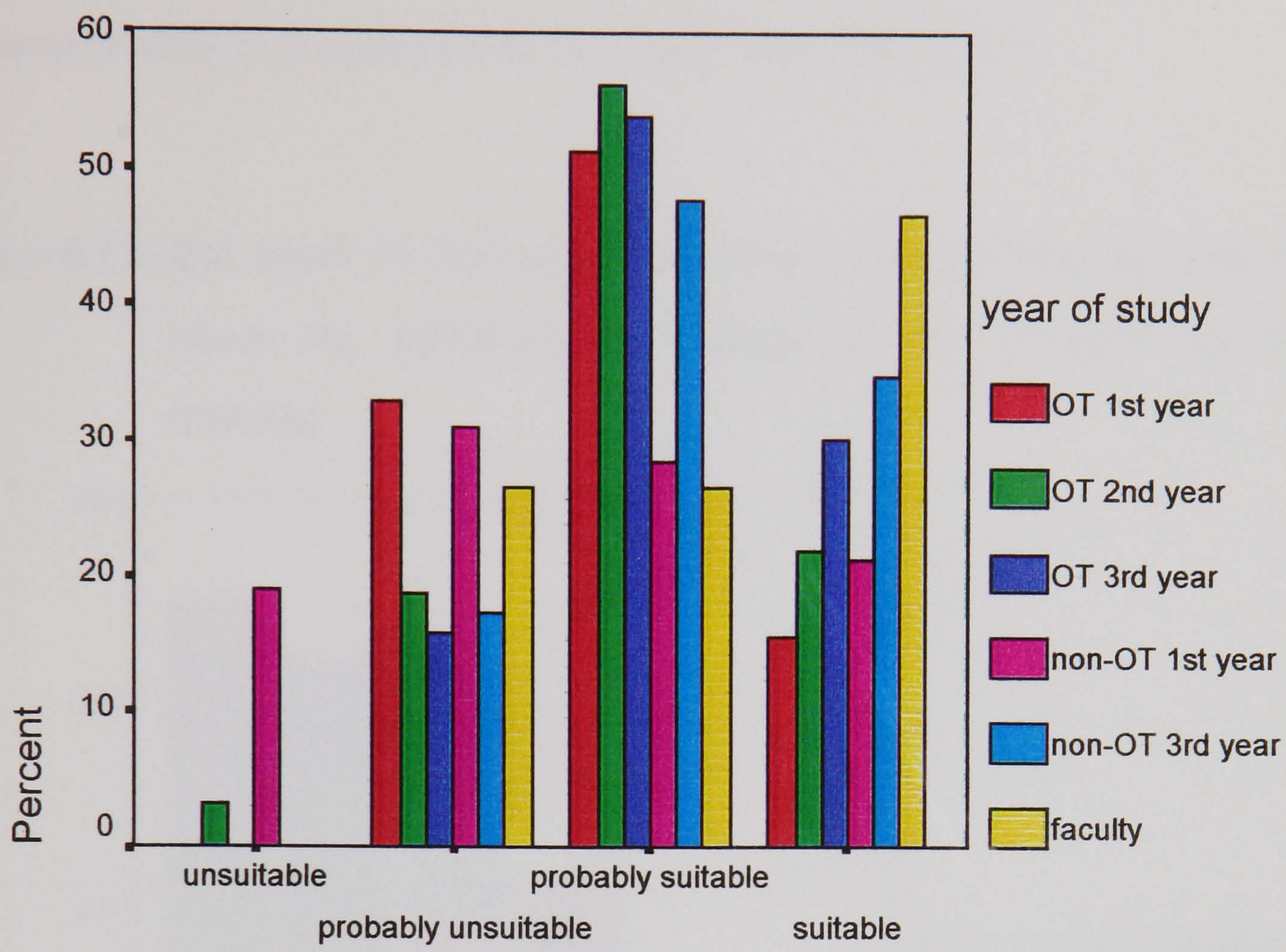


someone who has severe asthma

someone who is a wheelchair user

As might be expected, the non-OT students had a higher 'unsuitable'/ 'probably unsuitable' response rate (39%) in comparison to the OT students (24%). Interestingly, as Figure 6:12 shows, OT faculty were the most positive with 47% responding that someone who uses a wheelchair is suitable for training.

Figure 6:12: Bar chart to illustrate frequency of responses by course for suitability of 'someone who is a wheelchair user' for OT training



someone who is a wheelchair user

someone who is deaf

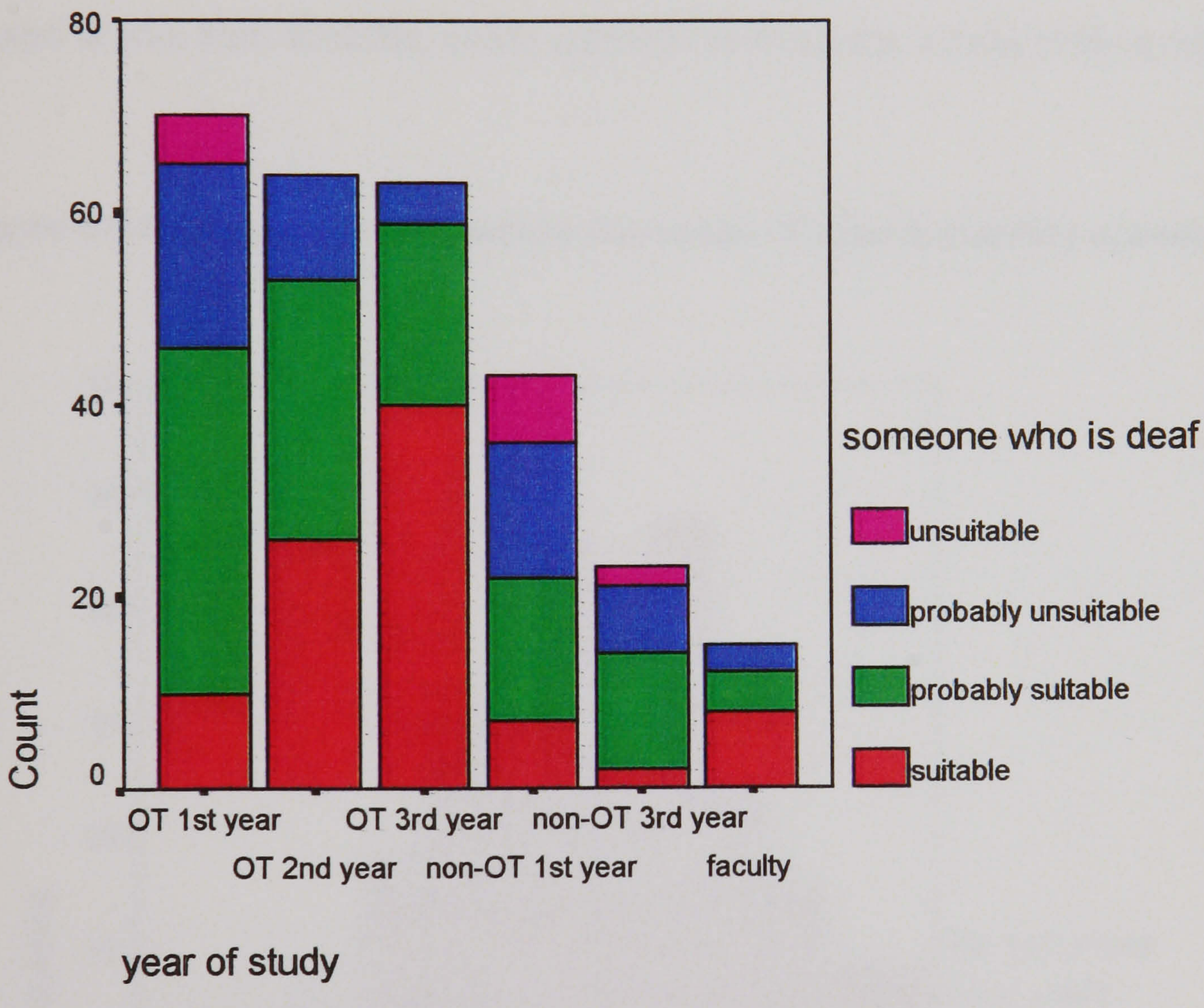
Responses to this item clearly illustrate the effects of experience. Amongst the OT students to begin their degree in 1993 (i.e. the intake following the OT respondent cohort for this study) was a student who was profoundly deaf. Experience of either teaching this student or seeing her as part of the student group might have influenced responses to this item. The relevant 'suitable' responses being:

OT faculty:	53%
2nd year OT students:	41%

3rd year OT students: 64%

in comparison to the overall 'suitable' response of 33%. In contrast, the combined 'unsuitable'/'probably unsuitable' responses of 1st year non-OT students is 49%, in comparison to the overall response of 26%.

Figure 6:13: Bar chart to illustrate frequency of responses by year of study for suitability of 'someone who is deaf' for OT training

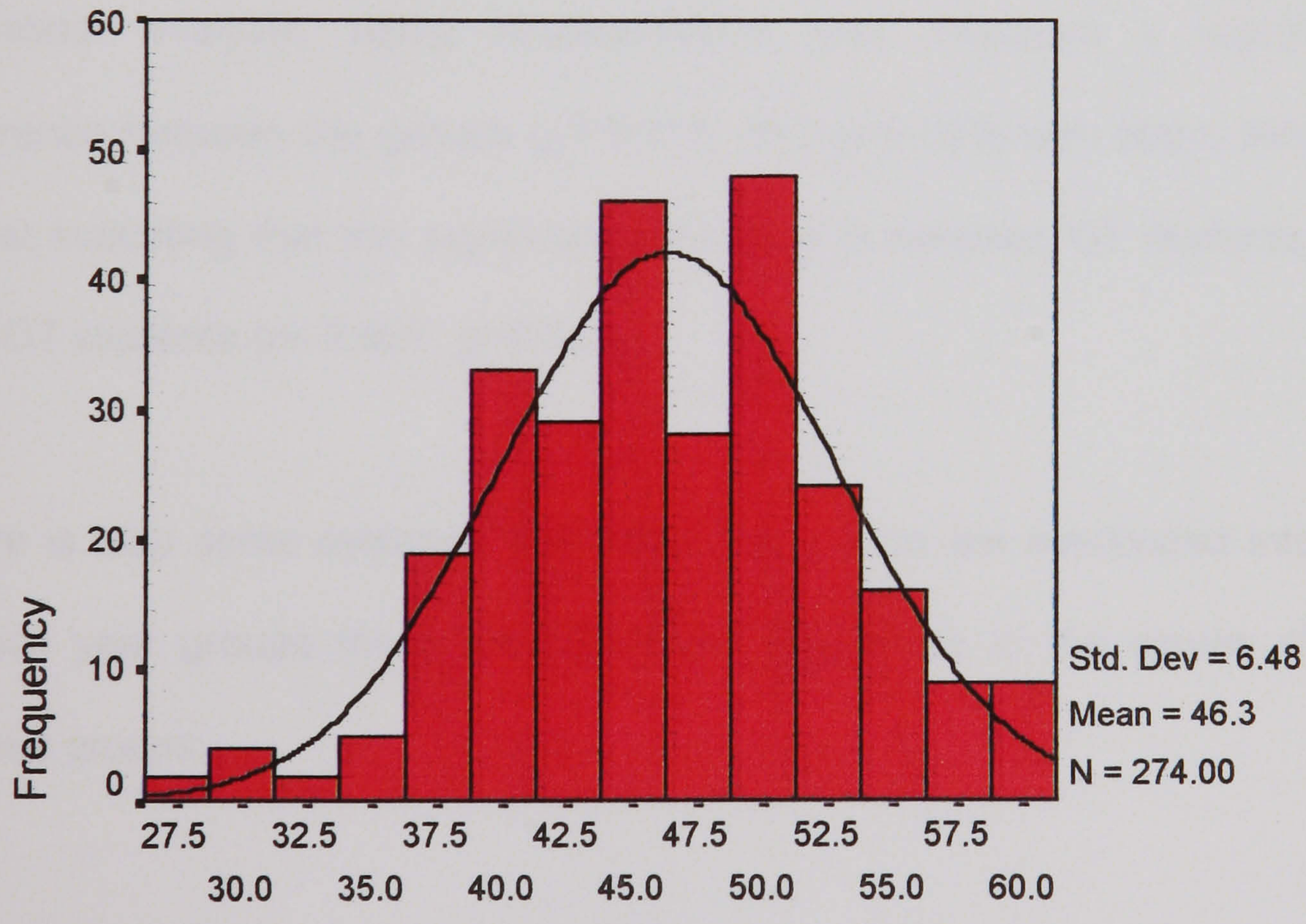


It could be argued that all the responses in this section can be drawn together to indicate an overall attitude towards the suitability of people with impairments or disabling conditions being admitted to training as OTs (the higher the score indicating a positive attitude towards disabled people as therapists). The scores for all 15 items on the suitability for OT training

section were added together to give an overall score for each respondent. The maximum score possible was 60, thus a score of 30+ can be seen as a positive attitude.

The mean score for all the respondents was 46.31 (*sd*=6.48, range=27-60), indicating a predominantly positive attitude towards disabled people training to become therapists. However, as Figure 6:14 illustrates, although 18% (n=48) of respondents had scores of 53+, a number of respondents had scores of less than 40 (20%, n=55) with 2% (n=4) having scores of 30 or less.

Figure 6:14: Histogram to illustrate the range of total suitability scores



There would appear to be some evidence to suggest that OT students (but not OT faculty) hold significantly more positive attitudes towards disabled people training as therapists than non-OT students.

Table 6:18: Total suitability to train scores for the main respondent groups

Respondent group	*mean total suitability score*	*standard deviation*
OT students (n=195)	47.16	5.98
OT faculty (n=15)	45.00	5.3
non-OT students (n=64)	44.05	7.6

Statistical analysis, using Kruskal-Wallis test, indicates a significant difference between the groups (χ^2=9.515, *df*=2 *p*=0.009) with Mann Whitney U test indicating that the significant difference is between OT students and non-OT students (*z*=-2.927, *p*=0.003).

There is also some evidence that when the groups are subdivided into the various year groups there are significant differences in the scores of the various groups.

Table 6:19: Total suitability scores for the different year groups

Respondent group	*mean total suitability score*	*standard deviation*
OT students		
1st years (n=70)	44.11	5.06
2nd years (n=64)	49.00	5.82
3rd years (n=61)	48.72	5.79
OT faculty (n=15)	45.00	5.30
non-OT students		
1st years (n=41)	43.29	8.52
3rd years (n=23)	45.39	5.52

If we rank these mean scores, we find that the non-OT 1st year group are the least in favour of disabled people training to be therapists and the OT 2nd year group are the most positive in their attitudes towards disabled people training to be therapists:

non-OT 1st years: 43.29

OT 1st years: 44.11

OT faculty: 45.00

non-OT 3rd years: 45.39

OT 3rd years: 48.72

OT 2nd years: 49.00.

Statistical analysis, using Kruskal-Wallis test, indicates a significant difference between the groups (χ^2=37.741, *df*=5 p<0.000). These differences are further illustrated in Table 6:20, which shows the results of post hoc

analysis using Mann Whitney U tests between the individual groups of respondents.

Table 6:20: Results of post hoc analysis of the total suitability scores for the different year groups

comparison	*z*	*p*
OT 1st year v. OT 2nd year	-4.613	<0.001*
OT 1st year v. OT 3rd year	-4.736	<0.001*
OT 1st year v. non-OT 1st year	-0.321	0.748
OT 1st year v. non-OT 3rd year	-0.745	0.456
OT 1st year v. OT faculty	-0.618	0.536
OT 2nd year v. OT 3rd year	-0.114	0.909
OT 2nd year v. non-OT 1st year	-3.410	0.001*
OT 2nd year v. non-OT 3rd year	-2.555	0.011*
OT 2nd year v. OT faculty	-2.242	0.025*
OT 3rd year v. non-OT 1st year	-3.495	<0.001*
OT 3rd year v. non-OT 3rd year	-2.572	0.010*
OT 3rd year v. OT faculty	-2.308	0.021*
Non-OT 1st year v. non-OT 3rd year	-0.862	0.389
Non-OT 1st year v, OT faculty	-0.723	0.470
Non-OT 3rd year v. OT faculty	-0.045	0.964

** indicates statistically significant differences*

From this table it can be seen, that whilst there is some evidence to suggest that OT students are more likely to see people with impairments and disabling conditions as suitable for admission to training as OTs, there is also evidence for the effects of experience and maturation on attitudes. This is shown by the significant differences between the 1st year OT students and both the 2nd years and 3rd year OT students, as well as the differences between non-OT 1st year students and OT 2nd and 3rd year students. Because of the lack of significant differences between OT and non-OT 1st year

students the effects of maturation and experience appear to be the most powerful. However, the exception to this is the evidence of the OT faculty who are significantly less positive than both the OT 2nd and 3rd year groups and less positive than the non-OT 3rd year group. This may be a reflection of more cautious responses from the OT faculty. Of the 15 items, only one item (someone who is blind) had responses in each of the 4 response categories from the OT faculty respondents. For all of the other items, either the 'suitable' or the 'unsuitable' response was not used. This could indicate that, whilst OT faculty respondents could be certain whether someone with a specific condition was definitely not 'suitable' or definitely not 'unsuitable', (i.e. no one thought 'someone with a history of schizophrenia' was 'suitable', and no one thought 'someone who has severe asthma' was 'unsuitable') they were more likely, because of experience of all the other variables involved in student selection, to choose one of the 'probably' responses.

It might be logical to assume that there would be a relationship between a positive ATDP score and a high total suitability score, as both could be seen as being aspects of a positive attitude towards disabled people. However, this does not appear to be the case. If we compare the rank orders of ATDP and total suitability scores we find that whilst the non-OT 1st year group had the lowest mean scores for both the ATDP and the total suitability score and the OT 2nd year group had the highest scores for both scales, the other groups are much more varied:

total suitability	*ATDP*
non-OT 1st years	non-OT 1st years
OT 1st years	non-OT 3rd years
OT faculty	OT 1st years
non-OT 3rd years	OT 3rd years
OT 3rd years	OT faculty
OT 2nd years	OT 2nd years.

Statistical analysis reveals that there is a positive correlation between the two sets of scores (r=0.400, p<0.000). The relationship between the findings for the various sections of the main questionnaire will be discussed in detail below.

Semantic differential: a stereotype of disability?

The final section of the main questionnaire utilised a semantic differential scale to create a profile of a 'disabled person'. Respondents were asked to rate a number of pairs of bipolar descriptors on a 6-point scale. By calculating the mean scores for each category the overall profile of a disabled person can be created.

Figure 6:15: Profile of 'a disabled person' using the overall mean scores for the semantic differential scale

self sufficient	_:_:x:_:_:_	needy
good health	_:_:x:_:_:_	poor health
unemotional	_:_:_:_:x:_	responsive
clear speech	_:_:x:_:_:_	unclear speech
misfit	_:_:_:_:x:_	accepted
helpless	_:_:_:_:x:_	competent
talkative	_:x:_:_:_:_	uncommunicative
valuable	_:x:_:_:_:_	worthless
secure	_:_:x:_:_:_	insecure
uncontrolled	_:_:_:_:x:_	controlled
deceitful	_:_:_:_:x:_	trustworthy
misunderstood	_:_:x:_:_:_	understood
trusting	_:_:x:_:_:_	wary
mature	_:x:_:_:_:_	childlike
an asset to society	_:x:_:_:_:_	a burden on society
dependent	_:_:_:x:_:_	independent
high self esteem	_:_:x:_:_:_	low self esteem
will find a job easily	_:_:_:_:x:_	won't find a job easily
tough	_:_:x:_:_:_	vulnerable
socially inept	_:_:_:_:x:_	socially skilled
contented	_:_:_:x:_:_	frustrated
insensitive to others	_:_:_:_:x:_	sensitive to others
employable	_:x:_:_:_:_	unemployable
introvert	_:_:_:x:_:_	extrovert
controlled by others/Fate	_:_:_:x:_:_	controlled by self
good looking	_:_:x:_:_:_	ugly
uncoordinated	_:_:_:x:_:_	graceful
physically attractive	_:_:x:_:_:_	physically unattractive

NB: to facilitate the creation of the profile the mean scores were rounded down if less than, or equal to, .5 and rounded up if more than .5.

Whilst the profile in Figure 6:15 should be viewed with caution because of the calculation of the data points, it does highlight that, whilst for the majority of the items (15, 54%) the responses fall in the mid range (3 or 4), a number of items have high or low scores which might indicate that these are key aspects of the profile of a disabled person. Taking items with mean scores of 2.5 and

less and 4.5 and over as being of note, the profile of a disabled person would appear to be:

item	*mean*	*mode*
responsive	4.7	5
clear speech	2.5	3
accepted	4.5	5
competent	4.6	4
talkative	2.3	2
valuable	1.7	1
controlled	4.6	5
trustworthy	5.0	6
mature	2.3	3
an asset to society	2.1	1
won't find a job easily	4.5	5
socially skilled	4.6	5
sensitive to others	4.7	5
employable	2.0	1

If we look at the mean scores for the main respondent groups, there do appear to be differences in the profiles of a disabled person which emerge. Statistical analysis of each item, using Kruskal-Wallis test with post hoc analysis using Mann Whitney U test, indicate a number of significant differences between OT students, non-OT students and OT faculty. Table 6:21 shows the mean score for each respondent group for each item of the semantic differential and indicates where there are significant differences

between groups. The mean scores have been used in table 6:21 to illustrate the differences between the groups, however, it should be noted that statistical analysis was by non-parametric tests and, as such, did not involve the comparison of mean scores. Non-parametric tests were used because of the size differentials between the various respondent groups, which would contravene the assumptions of any parametric test.

Table 6:21: Mean scores for semantic differential items for the main respondent groups

	OT students	*non-OT students*	*OT faculty*
Self sufficient/needy *	2.70 *	3.36 *	3.00
Good health/poor health *	2.51 *	2.95 **	2.17 *
Unemotional/responsive *	4.85 *	4.43 *	4.25
Clear speech/unclear speech	2.39 *	2.86 *	2.64
Misfit/accepted *	4.54 *	4.05 **	4.92 *
Helpless/competent *	4.75 *	3.96 **	4.75 *
Talkative/uncommunicative	2.23	2.61	2.82
Valuable/worthless *	1.55 *	2.05 *	1.42
Secure/insecure	2.87	2.89	2.50
Uncontrolled/controlled	4.58	4.33	4.83
Deceitful/trustworthy	5.13 *	4.70 *	5.09
Misunderstood/understood	3.39	3.19	3.42
Trusting/wary *	2.58 **	3.02 *	3.67 *
Mature/childlike *	2.16 *	2.60 *	2.17
An asset to society/ a burden on society *	1.92 *	2.54 *	2.25
Dependent/independent *	4.22 *	3.54 *	4.17
High self esteem/low self esteem *	3.03 **	3.36 *	3.83 *
Will find a job easily/ won't find a job easily *	4.44 *	4.81 *	3.92
Tough/vulnerable	3.09	3.27	3.33
Socially inept/socially skilled *	4.71 *	4.16 *	4.25
Contented/frustrated	3.55	3.71	3.67
Insensitive to others/ sensitive to others *	4.79 *	4.30 *	4.25
Employable/unemployable *	1.84 *	2.61 *	2.08
Introvert/extrovert	3.81	3.62	3.45
Controlled by others/ controlled by self *	4.24 *	3.75 *	3.75
Good looking/ugly *	2.61 *	3.13 *	3.00
Uncoordinated/graceful *	3.71 *	3.35 *	3.75
Physically attractive/ physically unattractive *	2.81 *	3.46 *	3.08

* indicates a significant difference between the groups with $p<0.05$. The colour of the * indicates the significant comparisons: * OT student/non OT student; * OT student/OT faculty; * OT faculty/non OT student.

It is interesting to note that 7 items did not show significant differences between the groups:

talkative/uncommunicative

secure/insecure;

uncontrolled/controlled;

misunderstood/understood;

tough/vulnerable;

contented/frustrated;

introvert/extrovert.

Two items showed significant differences between OT students and OT faculty:

trusting/wary;

high self esteem/low self esteem.

All other items showed significant differences between OT and non-OT students.

The mean scores for the three respondent groups have been used to create profiles of 'a disabled person', and to allow comparison between the profiles of the groups.

Figure 6:16: Profile of 'a disabled person' using the semantic differential mean scores for the OT student group

self sufficient	_:_:x:_:_:_	needy
good health	_:_:x:_:_:_	poor health
unemotional	_:_:_:_:x:_	responsive
clear speech	_:x:_:_:_:_	unclear speech
misfit	_:_:_:_:x:_	accepted
helpless	_:_:_:_:x:_	competent
talkative	_:x:_:_:_:_	uncommunicative
valuable	_:x:_:_:_:_	worthless
secure	_:_:x:_:_:_	insecure
uncontrolled	_:_:_:_:x:_	controlled
deceitful	_:_:_:_:x:_	trustworthy
misunderstood	_:_:x:_:_:_	understood
trusting	_:_:x:_:_:_	wary
mature	_:x:_:_:_:_	childlike
an asset to society	_:x:_:_:_:_	a burden on society
dependent	_:_:_:x:_:_	independent
high self esteem	_:_:x:_:_:_	low self esteem
will find a job easily	_:_:_:x:_:_	won't find a job easily
tough	_:_:x:_:_:_	vulnerable
socially inept	_:_:_:_:x:_	socially skilled
contented	_:_:_:x:_:_	frustrated
insensitive to others	_:_:_:_:x:_	sensitive to others
employable	_:x:_:_:_:_	unemployable
introvert	_:_:_:x:_:_	extrovert
controlled by others/Fate	_:_:_:x:_:_	controlled by self
good looking	_:_:x:_:_:_	ugly
uncoordinated	_:_:_:x:_:_	graceful
physically attractive	_:_:x:_:_:_	physically unattractive

As with the overall profile (Figure 6:15), if we remove the mid-range items the profile is somewhat reduced:

item	*mean*
responsive	4.9
clear speech	2.4
competent	4.8
talkative	2.2
valuable	1.6

controlled	4.6
trustworthy	5.1
mature	2.2
an asset to society	1.9
socially skilled	4.7
sensitive to others	4.8
employable	1.8

Not surprisingly, given the proportion of OT students to other respondents, this profile is almost identical to the overall profile. However, the high/low items have changed with removal of 'won't find a job easily'.

Figure 6:17: **Profile of 'a disabled person' using the semantic differential mean scores for the non-OT student group**

self sufficient	_:_:x:_:_:_	needy
good health	_:_:x:_:_:_	poor health
unemotional	_:_:_:x:_:_	responsive <-
clear speech	_:_:x:_:_:_	unclear speech ->
misfit	_:_:_:x:_:_	accepted <-
helpless	_:_:_:x:_:_	competent <-
talkative	_:_:x:_:_:_	uncommunicative ->
valuable	_:x:_:_:_:_	worthless
secure	_:_:x:_:_:_	insecure
uncontrolled	_:_:_:x:_:_	controlled <-
deceitful	_:_:_:_:x:_	trustworthy
misunderstood	_:_:x:_:_:_	understood
trusting	_:_:x:_:_:_	wary
mature	_:_:x:_:_:_	childlike ->
an asset to society	_:_:x:_:_:_	a burden on society ->
dependent	_:_:_:x:_:_	independent
high self esteem	_:_:x:_:_:_	low self esteem
will find a job easily	_:_:_:_:x:_	won't find a job easily ->
tough	_:_:x:_:_:_	vulnerable
socially inept	_:_:_:x:_:_	socially skilled <-
contented	_:_:_:x:_:_	frustrated
insensitive to others	_:_:_:x:_:_	sensitive to others <-
employable	_:_:x:_:_:_	unemployable ->
introvert	_:_:_:x:_:_	extrovert
controlled by others/Fate	_:_:_:x:_:_	controlled by self
good looking	_:_:x:_:_:_	ugly
uncoordinated	_:_:x:_:_:_	graceful <-
physically attractive	_:_:x:_:_:_	physically unattractive

the arrows -> <- indicate where the scores in this profile have moved in relation to those in the OT student profile

As the arrows indicate, the movement in the scores are all in the direction of what might be seen as the more negative poles of each trait, which might be seen to imply that non-OT students hold more negative beliefs about disabled people. However, the profile, excluding the mid-range items, is more limited than that of the OT student group. The list does, however, include 'won't find

a job easily' which was missing from the OT student list. The items included in this profile would be:

item	*mean*
valuable	2.1
trustworthy	4.7
an asset to society	2.5
won't find a job easily	4.8

The apparent clustering of scores around the mid-points needs to be explained. This is not due to a greater tendency of non-OT students to use the mid-points of the scale for their responses. In fact, the non-OT students appear to have used a wider range of response points. The non-OT student group was more likely to have responses in each of the six points for each item and for their responses to be more evenly spread across the six points, indicating a greater diversity of opinions than either the OT students or OT faculty.

Figure 6:18: Profile of 'a disabled person' using the semantic differential mean scores for the OT faculty group

self sufficient	_:_:x:_:_:_	needy
good health	_:x:_:_:_:_	poor health <-
unemotional	_:_:_:x:_:_	responsive <-
clear speech	_:_:x:_:_:_	unclear speech ->
misfit	_:_:_:_:x:_	accepted
helpless	_:_:_:_:x:_	competent
talkative	_:_:x:_:_:_	uncommunicative ->
valuable	x:_:_:_:_:_	worthless <-
secure	_:_:x:_:_:_	insecure
uncontrolled	_:_:_:_:x:_	controlled
deceitful	_:_:_:_:x:_	trustworthy
misunderstood	_:_:x:_:_:_	understood
trusting	_:_:_:x:_:_	wary ->
mature	_:x:_:_:_:_	childlike
an asset to society	_:x:_:_:_:_	a burden on society
dependent	_:_:_:x:_:_	independent
high self esteem	_:_:_:x:_:_	low self esteem ->
will find a job easily	_:_:_:x:_:_	won't find a job easily
tough	_:_:x:_:_:_	vulnerable
socially inept	_:_:_:x:_:_	socially skilled <-
contented	_:_:_:x:_:_	frustrated
insensitive to others	_:_:_:x:_:_	sensitive to others <-
employable	_:x:_:_:_:_	unemployable
introvert	_:_:x:_:_:_	extrovert <-
controlled by others/Fate	_:_:_:x:_:_	controlled by self
good looking	_:_:x:_:_:_	ugly
uncoordinated	_:_:_:x:_:_	graceful
physically attractive	_:_:x:_:_:_	physically unattractive

the arrows -> <- indicate where the scores in this profile have moved in relation to those in the OT student profile

The variations from the OT student profile are not consistently in a more positive or more negative direction. Items such as 'good health' move towards the more positive pole, but other items, such as 'trusting' and 'sensitive' to others, move towards the more negative pole. Excluding the mid-range items, the profile is more extensive than for the non-OT student group, but not as extensive as for the OT student group.

item	*mean*
good health	2.1
accepted	4.9
competent	4.7
valuable	1.4
secure	2.5
controlled	4.8
trustworthy	5.1
mature	2.1

Three items, which were not included in any of the other profiles, are included here. They are ‘good health’, 'accepted' and 'secure', and one item has been excluded from this profile 'won't find a job easily'.

If we take the non-OT student profile as a baseline, we can get a picture of 'a disabled person' as someone who is trustworthy and a valued asset to society but who will have difficulty finding a job, but other than that has no clearly distinguishing features. In contrast to this the profile of 'a disabled person' given by the OT student group is much more extensive and gives a much more positive and rounded picture of a healthy, communicative, attractive and mature individual, who will still have difficulty in getting a job.

Statistical analysis of each item, using Kruskal-Wallis test with post hoc analysis using Mann Whitney U test, indicate a number of significant differences between the various respondent groups, although not dramatically different from the results given for the respondents when they

are divided into OT and non-OT groups. As Table 6:22 shows, there are some interesting differences in the results when the respondents are divided into their year groups. It should be noted again that, whilst Table 6:22 uses the mean scores to illustrate the comparisons between the groups, statistical analysis was by non-parametric test because of the size differentials between the various respondent groups

Table 6:22: Mean scores for semantic differential items for the different year groups

	OT1	OT2	OT3	non-OT1	non-OT3	OT faculty
Self sufficient/needy *	2.86 *	2.67 *	2.57 *	3.40 * * *	3.27 * *	3.00
Good health/poor health	2.52	2.50	2.50	3.00 *	2.83	2.16 *
Unemotional/responsive	4.81	4.82	4.92	4.44	4.38	4.25
Clear speech /unclear speech	2.55	2.21 *	2.40 *	3.10 * *	2.33	2.63
Misfit/accepted	4.44	4.63 *	4.55	4.08	4.00 *	4.91
Helpless/competent *	4.67 *	4.75 *	4.82 *	3.86 * * *	4.16 * * *	4.75
Talkative/uncommunicative	2.29	2.21	2.17	2.63	2.55	2.81
Valuable/worthless	1.49 *	1.54 *	1.69	2.10 * *	1.94 *	1.41
Secure/insecure	2.98	2.89	2.74	3.05	2.55	2.50
Uncontrolled/controlled	4.43	4.56	4.75 *	4.12 *	4.77	4.83
Deceitful/trustworthy	5.13 *	5.06	5.19 *	4.57 * *	4.94	5.09
Misunderstood/understood	3.30	3.46	3.39	2.94	3.72	3.41
Trusting/wary *	2.61 *	2.67 *	2.45 *	3.02 *	3.00	3.66 * * *
Mature/childlike	2.16 *	2.15 *	2.14 *	2.71 * * *	2.33	2.16
An asset to society/a burden on society	1.83 *	1.98	1.95 *	2.61 * *	2.38 *	2.25
Dependent/independent *	4.04 *	4.31 *	4.30 *	3.42 * * *	3.77	4.16
High self esteem/low self esteem *	3.12 *	2.93 *	3.01	3.28	3.50 *	3.83 * * *
Will find a job easily/won't find a job easily *	4.63	4.42 *	4.25 *	4.87 * *	4.66	3.91
Tough/vulnerable	3.06	3.20	3.01	3.50	2.77	3.33
Socially inept/socially skilled *	4.67 *	4.73 *	4.72 *	4.00 * * *	4.50	.250
Contented/frustrated	3.80	3.51	3.32	3.73	3.66	3.66
Insensitive to others/sensitive to others	4.83 *	4.82 *	4.71	4.31	4.27 * *	4.25
Employable/unemployable *	1.93 *	1.84 *	1.72 *	2.65 * * *	2.50 * * *	2.08
Introvert/extrovert	3.72	3.75	3.96 *	3.45 *	3.94	3.45
Controlled by others/ controlled by self	4.18	4.21	4.32 *	3.68 *	3.88	3.75
Good looking/ugly *	2.56 *	2.53 *	2.72 *	3.13 * * *	3.11 * * *	3.00 *
Uncoordinated/ graceful	3.55	3.76	3.80 *	3.34 * *	3.35 * *	3.75
Physically attractive/ physically unattractive *	2.78 *	2.76 *	2.86 *	3.48 * * *	3.41 * * *	3.08

* indicates a significant difference between the groups with $p<0.05$. The colour of the * indicates the significant comparisons: * OT1; * OT2; * OT3, * non-OT1.

Table 6:22 highlights, again, that the non-OT 1st year group holds the least positive attitudes towards disabled people, with significant differences with at least one OT group on 19 items. For only three item, 'sensitive/insensitive to others', 'misfit/accepted' and 'high self esteem/low self esteem', the

significant difference is between an OT student group and the non-OT 3rd year group rather than the non-OT 1st year group. For two items, 'trusting/wary' and 'high self esteem/low self esteem', there are significant differences between the OT faculty and the OT student groups, with the faculty appearing to hold the most negative perceptions of disabled people. The value and necessity of collapsing and expanding data by different groups is highlighted by the presence of results which show significant differences between years of students but not between the main groups ('uncontrolled/controlled' and 'introvert/extrovert'). It is also interesting to note that the OT student year groups are not significantly different in their perceptions of disabled people.

The final stage in the analysis of the semantic differential data was to explore whether the items in the semantic differential part of the questionnaire had any relationship to each other and whether the profile of perceptions of disabled people could be reduced to an overall pattern. This was done by analysing the data using factor analysis. The factor analysis revealed 6 factors. Thus the profile of 'a disabled person' can be reduced to 6 key components.

Table 6:23: Results of a factor analysis of the semantic differential data

	factor 1	factor 2	factor 3	factor 4	factor 5	factor 6
self sufficient/needy		.647				
good health/poor health		.547				
unemotional/responsive	-.618					
clear speech/unclear speech		.669				
misfit/accepted		-.603				
helpless/competent		-.633				
talkative/uncommunicative	.567					
valuable/worthless	.759					
secure/insecure						
uncontrolled/controlled						
deceitful/trustworthy	-.714					
misunderstood/understood						.676
trusting/wary						
mature/childlike	.684					
an asset to society/ a burden on society	.677					
dependent/independent			.688			
high self esteem/ low self esteem				.554		
will find a job easily/ won't find a job easily				.653		
tough/vulnerable				.621		
socially inept/socially skilled						
contented/frustrated				.647		
insensitive to others/ sensitive to others	-.635					
employable/unemployable						
introvert/extrovert						
controlled by others/ controlled by self			.660			
good looking/ugly					.715	
uncoordinated/graceful			.678			
physically attractive/ physically unattractive					.708	

Extraction Method: Principal Component Analysis
Rotation Method: Varimax with Kaiser Normalisation

The Eigenvalues and % of variance for each of the factors are:

1. 9.738, 34.8%
2. 2.103, 7.5%
3. 1.449, 5.2%
4. 1.315, 4.7%
5. 1.130, 4.1%

6. 1.033, 3.7%.

The 6 factors appear to represent:

factor 1		
unemotional/responsive	}	
talkative/uncommunicative	}	
valuable/worthless	}	
deceitful/trustworthy	}	*positive image*
mature/childlike	}	
an asset to society/	}	
a burden on society	}	
insensitive to others/	}	
sensitive to others	}	
factor 2		
self sufficient/needy	}	
good health/poor health	}	*perception of need*
clear speech/unclear speech	}	
helpless/competent	}	
factor 3		
dependent/independent	}	
controlled by others	}	
controlled by self	}	*control*
uncoordinated/graceful	}	
factor 4		
high self esteem/	}	
low self esteem	}	
will find a job easily/	}	
won't find a job easily	}	*self concept*
tough/vulnerable	}	
contented/frustrated	}	
factor 5		
good looking/ugly	}	
physically attractive/	}	*appearance*
physically unattractive	}	
factor 6		
misunderstood/understood	}	*understanding*

By looking at the factors identified with the items which do and do not show significant differences between groups and years of students it is possible to

discussed. As the respondent groups for this part of the study, unlike the respondent groups for the main questionnaire part of the study, were all OT students, they form an homogeneous group, with similar numbers of respondents in both the 'personal' (n=55) and the 'professional' (n=56) groups. Statistical analysis was, therefore, by parametric tests.

Table 6:24: Demographic information for the personal/professional attitudes questionnaire

average age	25.29
sd	6.68
range	19 - 47
female: male ratio	57:5
% female	91.9%
module studied	
1528	15 [24.2%]
1918	21 [33.9%]
1261	26 [41.9%]

Analysis of the data reveals that there are no significant differences between the personal and professional attitudes towards disabled people held by OT students. The mean 'personal' ATDP score was 137.05 (*sd*=13.18, range=107-163). The mean 'professional' ATDP score was fractionally lower at 136.25 (*sd*=13.11, range=107-159). Of the completed questionnaires 45 provided matched data. The mean ATDP scores for the matched data (n=45) were virtually identical to the overall data ('personal' mean score=137.8, *sd*=13.09; 'professional' mean score=136.67, *sd*=13.46). Statistical analysis,

using t test for paired samples, not surprisingly, revealed no significant difference between the scores (t=0.73, df=44, p=0.467). As this was a repeated measures design it was felt appropriate to make sure that no order effect was present. Table 6:25 gives the mean scores for both 'personal' and 'professional' attitudes depending on whether the 'professional' questionnaire was completed first or second.

Table 6:25: Comparison of 'personal' and 'professional' ATDP mean scores for an order effect

	completed 1st		completed 2nd	
	mean score	*sd*	mean score	*sd*
professional	136.74	12.38	135.42	14.52
personal	134.92	11.57	139.25	14.54

T tests for independent samples show that there is no order effect as there are no significant differences between 'professional' attitudes (t=0.36, df=54, p=0.72) and 'personal' attitudes (t=1.22, sd=53, p=0.226) depending on whether the 'personal' or 'professional' questionnaire was completed first or second. These results are in marked contrast to those of Vargo and Semple (1988). They found that physiotherapy students' professional attitudes were significantly more positive than their personal attitudes, using the ATDP-A. Their mean scores were less positive than those of the current study. Their mean professional score was 114.30 (sd=24.58) and the mean personal score was 108.35 (sd=21.67).

As this questionnaire was a small sub-section of the study, replicating a previous study (Vargo & Semple, 1988), it was not felt to be appropriate to analyse the ATDP data in as much depth as the ATDP data from the main questionnaire. Individual item analysis and factor analysis were, therefore, not considered appropriate for this part of the study.

Findings from the disability social distance questionnaire

The final part of the study was the social distance questionnaire, given to three separate groups of OT students (1st, 2nd & 3rd year students), which was based on the DSDS developed by Tringo (1970) and used by Lyons and Hayes (1993) in their study of OT students.

Table 6:26: Demographic information for the social distance questionnaire

Respondent group	*average age [sd]*	*female: male ratio [% female]*
1st year (n=74)	23.31 [6.64]	70:2 [97.2%]
2nd year (n=67)	24.37 [5.63]	63:4 [94%]
3rd year (n=31)	24.54 [5.67]	31:0 [100%]

The DSDS lists 21 disabilities and conditions and asks respondents to rate each item on a 9-point scale, 1 (would marry) being the most intimate contact and 9 (would put to death) the most extreme avoidance. Each rating was converted to a Thurstone-type scale value as follows:

would marry 0.33

would accept as close kin by marriage	0.57
would have as next door neighbour	0.85
would accept as casual friend	1.06
would accept as fellow worker	1.21
would keep away from	2.95
would keep in an institution	3.14
would send out of my country	3.65
would put to death	4.69 (Tringo, 1970).

In addition the scores for the 21 items were totalled and the mean calculated to give each respondent an overall social distance score. Due to the disparity in group sizes, it was deemed more appropriate to use non-parametric tests to analyse these data. Table 6:27 gives an overview of the mean scores for each disability category for each group of respondents and indicates where there are significant differences between the scores for the different year groups. Although there are few significant differences between the groups, it should be noted that where there are significant differences it is the 3rd year group who tend to be the least positive in their attitudes. It should also be noted that the results as a whole indicate that the 3rd year students hold the least positive attitudes, in terms of social distance, of all three year groups. Not only is the mean overall social distance score for this group higher, indicating greater social distance, the mean scores for each item are higher for the 3rd year students for all disability variables except alcoholic, where the 1st year group are least positive, and hunchback, where the 2nd year group are least positive. The lowest mean scores for the various disability variables are equally divided between 1st years (10 items) and 2nd years (11 items).

However, any conclusions that 3rd year students hold less positive attitudes, in terms of social distance, must be viewed with some caution in the light of the relatively small number of 3rd year students who completed the DSDS.

Table 6:27: Group means for the Disability Social Distance Scale

disability variable	all groups *mean*	*sd*	1st year *mean*	*sd*	2nd year *mean*	*sd*	3rd year *mean*	*sd*
Alcoholic *	1.1354	.7830	1.3792*	.9452	0.9143*	.5857	1.0394	.5581
Amputee	0.4978	.2123	0.4924	.2150	0.4679	.1848	0.5752	.2469
Arthritis *	0.4428	.1754	0.4478	.1740	0.4030*	.1490	0.5171*	.2087
Asthma	0.3585	.0882	0.3568	.0885	0.3515	.0690	0.3777	.1197
Blindness *	0.4777	.1740	0.4592*	.1565	0.4627*	.1820	0.5545**	.1809
Cancer	0.4925	.2710	0.4668	.1779	0.4940	.3515	0.5487	.2490
Cerebral palsy	0.6330	.2070	0.6292	.1898	0.6152	.1896	0.6803	.2724
Deafness	0.4649	.1936	0.4628	.1977	0.4573	.1996	0.4865	.1740
Diabetes	0.3789	.1288	0.3738	.1212	0.3664	.0987	0.4181	.1883
Dwarf	0.6634	.2763	0.6221	.2049	0.6899	.3487	0.7010	.2342
Epilepsy *	0.4495	.1896	0.4395*	.1796	0.4278*	.1805	0.5203**	.2195
Ex-convict *	1.0517	.7812	1.1423	.6713	0.8918*	.6713	1.1813*	.7580
Heart disease	0.4507	.1798	0.4404	.1747	0.4406	.1760	0.4968	.1977
Hunchback	0.6745	.2979	0.6386	.2175	0.7074	.3732	0.6887	.2810
Mental handicap *	0.7325	.2707	0.7039*	.3133	0.7293	.2314	0.8061*	.2348
Mental illness	0.7387	.4174	0.7429	.4331	0.7287	.4655	0.7506	.2452
old age	0.5939	.2452	0.5547	.1403	0.6248	.3378	0.6194	.1897
Paraplegic *	0.5396	.2090	0.5611*	.2074	0.4878**	.1784	0.6010*	.2516
Stroke	0.5222	.1735	0.4971	.1499	0.5242	.1729	0.5771	.2152
Tuberculosis	0.6482	.4975	0.6284	.4628	0.6549	.5440	0.6803	.4850
Ulcer	0.4636	.1873	0.4497	.1691	0.4664	.1960	0.4903	.2110
Overall	0.5902	.1653	0.5913	.1614	0.5686	.1593	0.6338	.1824

* indicates a significant difference, using Kruskal-Wallis tests with post hoc analysis using Mann Whitney U tests, between the groups with $p<0.05$.
The colour of the * indicates the significant comparisons: * 1st year; * 2nd year.

If the mean scores are put into rank order, a disability hierarchy can be seen and the hierarchies of each respondent group compared. *(see Table 6:28, overleaf).*

Table 6:28: Disability Hierarchy for total sample and all groups

disability variable	rank (all)	rank (1st years)	rank (2nd years)	rank (3rd years)
asthma	1 [0.36]	1	1	1
diabetes	2 [0.38]	2	2	2
arthritis	3 [0.44]	5	3	6
epilepsy	4 [0.45]	3	4	7
heart disease	5 [0.45]	4	5	5
ulcer	6 [0.46]	6	8	4
deafness	7 [0.46]	8	6	3
blindness	8 [0.48]	7	7	9
cancer	9 [0.49]	9	11	8
amputee	10 [0.50]	10	9	10
stroke	11 [0.52]	11	12	11
paraplegia	12 [0.54]	13	10	12
old age	13 [0.59]	12	14	13
cerebral palsy	14 [0.63]	16	13	14
tuberculosis	15 [0.65]	15	15	14
dwarf	16 [0.66]	14	16	17
hunchback	17 [0.67]	17	17	16
mental handicap	18 [0.73]	18	19	19
mental illness	19 [0.74]	19	18	18
ex-convict	20 [1.05]	20	20	21
alcoholism	21 [1.14]	21	21	20

The disability hierarchies in Table 6:28 indicate, in combination with Table 6:27, that there are differences between the year groups in their perceptions of the different disability variables. Perhaps the most noteworthy are the differences for epilepsy, ulcer and deafness, where the ranks in the hierarchy vary by 4 or more places. The rank for epilepsy ranges from 3rd for the 1st year group to 7th for the 3rd year group; for ulcer it ranges from 4th for the 3rd year group to 8th for the 2nd year group; and for deafness the rank ranges from 3rd for the 3rd year group to 8th for the 1st year group. The high rank for deafness with the 3rd year group might be explained by the positive effects of

contact, as this 3rd year group had a profoundly deaf student amongst their number.

Comparison of the data for the current study with that of both Tringo's (1970) and Lyons and Hayes' (1993) reveals some interesting similarities and differences. Tringo's respondent groups were undergraduate students on a range of professional courses. Lyons and Hayes' respondents were OT students across the four years of their undergraduate course. It should be noted that Lyons and Hayes only identified the top and bottom six disabilities.

Table 6:29: Comparison of Disability Hierarchies with those of Tringo (1970) & Lyons & Hayes (1993)

disability variable	rank (current)	rank (Lyons & Hayes)	rank (Tringo)
asthma	1	1	2
diabetes	2	2	4
arthritis	3	3	3
epilepsy	4		12
heart disease	5	6	5
ulcer	6	5	1
deafness	7		7
blindness	8		8
cancer	9		10
amputee	10	4	6
stroke	11		9
paraplegia	12		13
old age	13		11
cerebral palsy	14	17	15
tuberculosis	15		14
dwarf	16		16
hunchback	17	16	17
mental handicap	18	18	18
mental illness	19	19	20
ex-convict	20	21	19
alcoholism	21	20	21

Whilst the bottom of the hierarchy is similar for all three studies, there are a number of interesting differences towards the top of the hierarchy. Tringo ranks ulcer as 1st but both OT studies had ulcer lower down the list at 6th and 5th, Epilepsy was viewed much more positively in the current study (4th) in comparison with Tringo (12th) and Lyons and Hayes (no rank given), but amputee was seen more negatively, 10th in the current study in comparison to 4th (Lyons and Hayes) and 6th (Tringo).

The final analysis of these data used a Pearson correlation and a factor analysis to establish the inter-correlation and relationships between the disability variables. Table 6:30 shows the correlation between the disability variables, including the overall social distance score.

Table 6:30: Intercorrelation matrix for items on the Disability Social Distance Scale

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1. alcoholic		.15	.17	.24	.10	.14	.12	.12	.07	.16	.11	.38	.27	.11	.09	.35	.04	.24	.17	.09	.11	.49
2. amputee			.51	.43	.54	.29	.45	.49	.45	.31	.41	.27	.41	.33	.32	.23	.11	.55	.39	.38	.35	.59
3. arthritis				.54	.47	.39	.41	.48	.67	.27	.51	.30	.53	.36	.35	.24	.16	.50	.47	.45	.39	.67
4. asthma					.44	.32	.39	.37	.59	.22	.52	.23	.35	.28	.32	.25	.17	.49	.39	.58	.42	.61
5. blindness						.47	.48	.61	.42	.28	.43	.14	.44	.28	.31	.25	.21	.53	.44	.45	.39	.58
6. cancer							.48	.39	.44	.16	.33	.16	.63	.29	.29	.27	.15	.35	.32	.29	.34	.53
7. cerebral palsy								.43	.39	.44	.45	.29	.45	.41	.41	.30	.24	.47	.46	.34	.35	.64
8. deafness									.56	.45	.51	.25	.37	.28	.34	.36	.19	.58	.42	.14	.39	.63
9. diabetes										.23	.63	.27	.39	.27	.31	.25	.12	.50	.45	.19	.45.	.62
10. dwarf											.31	.32	.23	.42	.39	.45	.28	.39	.27	.23	25	.52
11. epilepsy												.24	.33	.32	.34	.29	.14	.51	.46	.48	.41	.62
12. ex-convict													.28	.17	.25	.26	.15	.31	.22	.18	.29	.61
13. heart disease														.33	.36	.41	.23	.45	.47	.38	.39	.67
14. hunchback															.45	.33	.26	.32	.39	.36	.43	.56
15. mental handicap																.63	.33	.35	.22	.42	.29	.61
16. mental illness																	.18	.36	.26	.36	.16	.63
17. old age																		.24	.22	.14	.10	.24
18. paraplegic																			.55	.52	.41	.71
19. stroke																				.49	.52	.63
20. tuberculosis																					.53	.64
21. ulcer																						.59
22. overall																						

The correlations are all positive and range from .04 to .71, indicating that although a close social distance score for one disability variable (e.g. asthma) will indicate a similar score for another disability variable (e.g. dwarf) the similarities will be stronger for some variables (e.g. diabetes and arthritis) than for other variables (e.g. alcoholic and old age). With few exceptions, the correlations are higher with the overall social distance than with any other disability variable, indicating that the overall scores will give a clear indication of the social distance for any other disability variable. Factor analysis revealed groupings giving four factors which are shown in Table 6:31.

Table 6:31: Results of a factor analysis of the Disability Social Distance Scale data

	factor 1	factor 2	factor 3	factor 4
alcoholic				.85594
amputee	.62954			
arthritis	.68314			
asthma	.71743			
blindness	.59326			
cancer			.83451	
cerebral palsy				
deafness	.62478			
diabetes	.77795			
dwarf		.70063		
epilepsy	.73467			
ex-convict				.63769
heart disease			.72983	
hunchback		.58444		
mental handicap		.73847		
mental illness		.63349		
old age		.59078		
paraplegia	.65850			
stroke	.64442			
TB	.70331			
ulcer	.62876			

Extraction Method: Principal Component Analysis
Rotation Method: Varimax with Kaiser Normalisation

The Eigenvalues and percentage of variance for each of the factors are:

1. 8.326, 39.6%
2. 1.645, 7.8%
3. 1.223, 5.8%
4. 1.065, 5.1%.

Whilst the majority of disability variables, and the variance, are located within factor 1, the variables within the other factors highlight interesting divisions

and levels of acceptance for different disabilities. Factor 1 could be seen as 'physical' disabilities, and more acceptable, whilst the other factors are 'disfiguring' or 'mental' conditions (factor 2), 'killers' (factor 3) and 'undesirable personalities' (factor 4), all of which are seen as less acceptable.

If the disability hierarchy from the Disability Social Distance Scale and the hierarchy of suitability to train as an OT are compared, we find that there are some interesting differences between the hierarchies, indicating that attitudes, in terms of social distance, are different for personal and professional social distance. Although mental health problems are at the bottom of both hierarchies, other disabilities and conditions are more or less acceptable socially or within the profession. For example, it might be seen as acceptable to have a close personal relationship with someone who is asthmatic, but this person would not be seen as appropriate to train as an OT, the same is true of someone who is deaf or blind. In contrast, someone with an above knee amputation is seen as appropriate to train as an OT but less appropriate for a closer personal relationship. Thus, it might be concluded that whilst personal and professional attitudes, as measured by the ATDP, are not different, personal and professional attitudes as measured by social distance are, in fact, somewhat different.

The effect of contact with disabled people

As chapter 4 highlighted, contact with disabled people has been shown to have an influence on attitudes towards disabled people, even if the evidence appears to be that the effects of contact are complex. Respondents to the

main questionnaire and respondents to the personal/professional attitudes questionnaire were asked to indicate how much contact they had had with disabled people. The contact questions asked whether the respondent

had a family member who was disabled;

had worked with a disabled person as a colleague;

had a friend who was disabled;

was her/himself disabled;

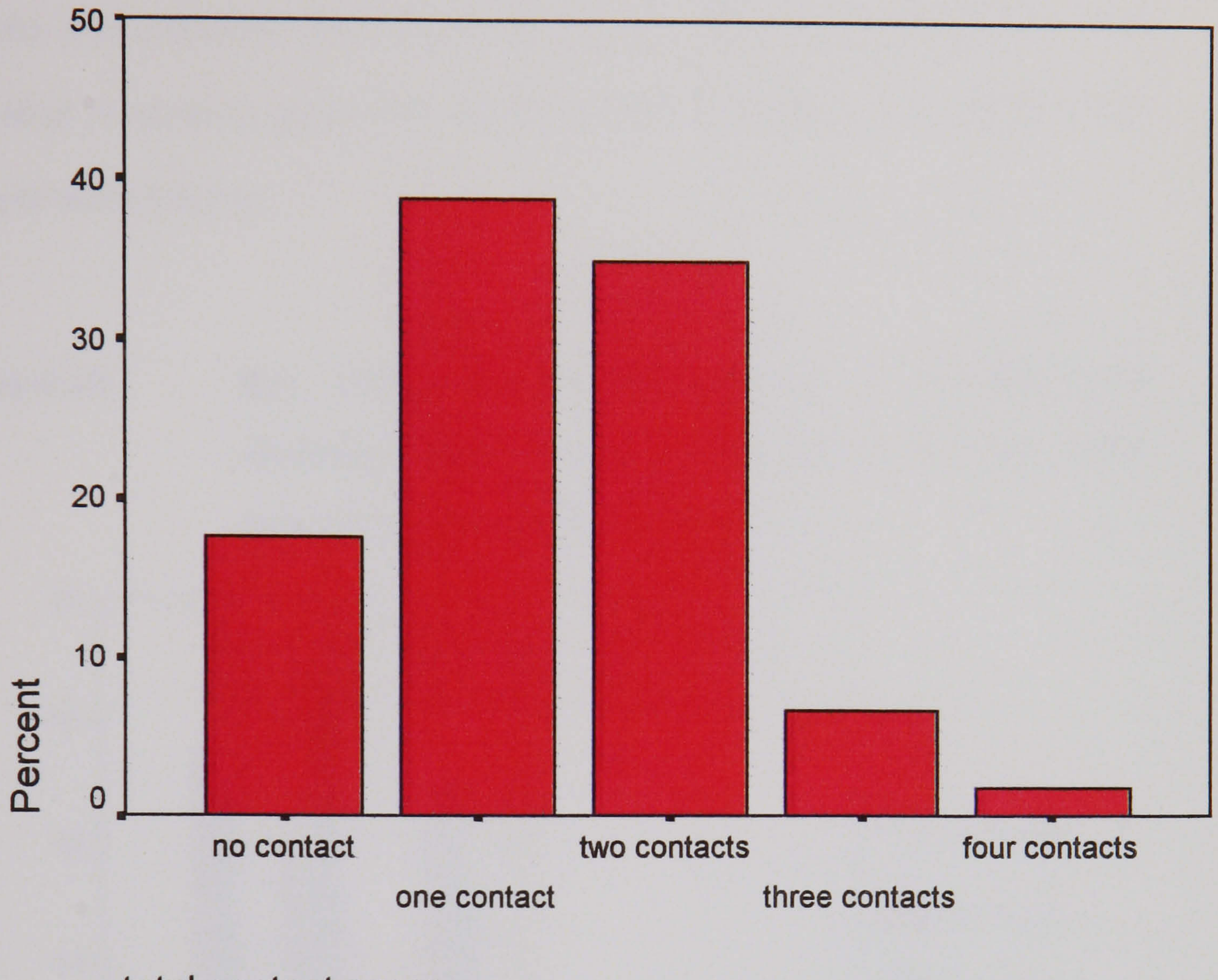
knew no-one who was disabled.

The responses to each question were also totalled to give a total contact score.

Effects of contact for the main questionnaire

As Figure 6:19 shows, respondents to the main questionnaire had experienced a wide range of contact from no contact (17.7%) to all four contacts (1.8%). The majority of respondents, however, indicated one (38.9% or two (35%) contacts.

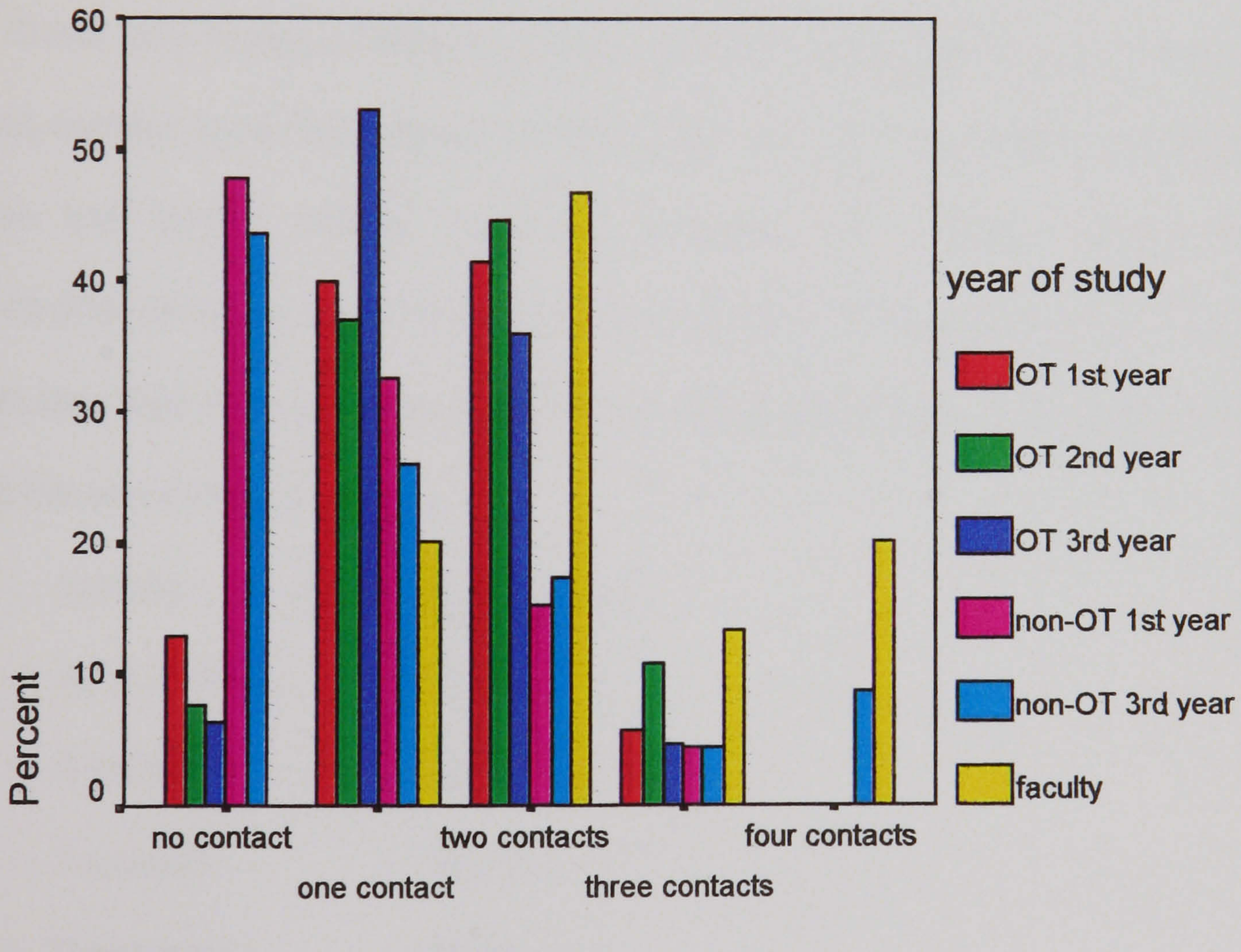
Figure 6:19: **Bar chart showing the amount of contact with disabled people for respondents to the main questionnaire**



The nature of the contact would appear to be with either disabled colleagues (62% of respondents) or disabled friends (51%). The level of contact with disabled people as colleagues may be deceptively high. It is questionable whether respondents, especially the OT students, answered this question as 'worked with a disabled person', interpreting that to be either as a colleague or as a patient. Although it could be seen as a positive indication of client-centred practice if the OT students were, in fact, seeing their disabled patients/clients as colleagues. The non-OT student groups were more likely

to have had no contact with disabled people, as can be seen in Figure 6:20. 47.8% of 1st year non-OT students and 43.5% of 3rd year non-OT students indicated that they knew no-one who was disabled. The number of OT students who indicated that they knew no-one who was disabled (9%) was somewhat surprising given the nature of the profession for which these students were training.

Figure 6:20: **Bar chart showing the amount of contact with disabled people for respondents to the main questionnaire by year of study**



The area where the majority of OT students indicated contact with disabled people was as a colleague, 70% of OT students as compared with 30% of

non-OT students had worked with a disabled person as a colleague. Responses to 'friend' and 'family member' were more similar when the groups and year groups were compared.

Lyons (1990), in his study comparing OT and non-OT students using the ATDP-A, found no differences between student groups, but significant differences based on amounts of contact with disabled people. Statistical analysis of the ATDP scores for the different amounts of contact in this study also indicates that contact has a significant effect on attitudes towards disabled people. However, the relationship between attitudes and contact is, as Yuker and Hurley (1987) conclude, complex. Although the group with the most contact have the highest ATDP scores and the group with no contact have the lowest scores, statistical analysis, with Kruskal Wallis test (χ^2=9.903, *df*=4, *p*=0.042) and post hoc analysis with Mann Whitney U tests, indicates that the significant differences are between the no contact group and the two contacts group:

contact	*ATDP mean scores*
no contact	125.12
3 contacts	133.45
1 contact	138.58
2 contacts	136.06
4 contacts	137.40.

Further analysis indicates that whilst the amount of contact may have no more effect than contact as opposed to no contact, the nature of the contact can have a significant effect. Analysis, using Mann Whitney U tests, indicates

that whilst having a disabled family member, a disabled friend or a disability oneself does not affect attitudes, respondents who had worked with a disabled colleague were significantly more positive in their attitudes than those who had not (z=-3.606, p<0,000). Interestingly, whilst the mean scores for respondents with a disabled friend were more positive than those who did not have any disabled friends (135.90, 132.14), mean scores for respondents with a disabled family member were very slightly more negative than respondents without disabled family members (133.68, 134.14).

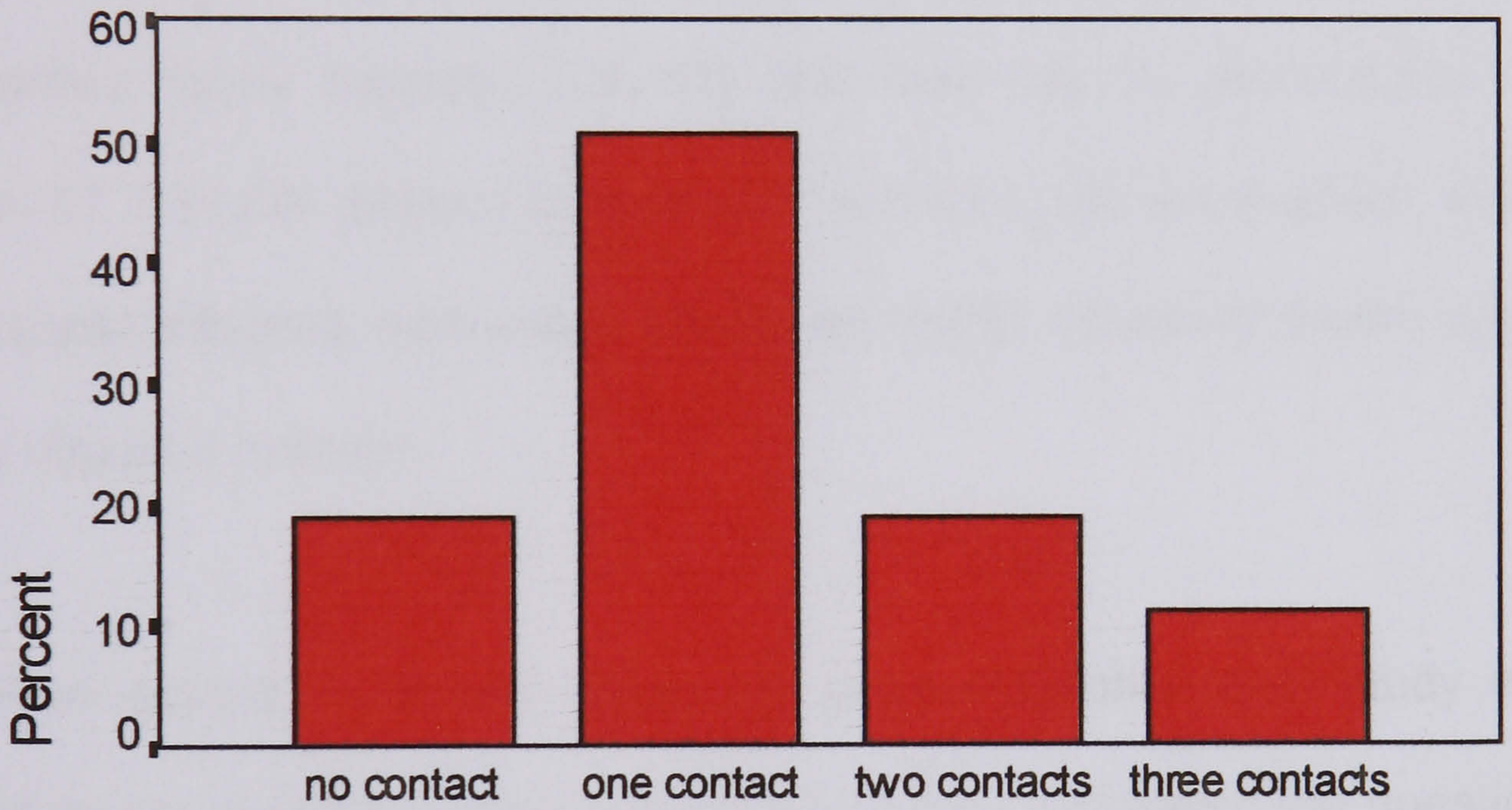
Given the apparent positive effect of working with a disabled colleague, it might be reasonable to assume that contact might affect perceptions of who is suitable to train as an OT. There is some evidence that contact does affect attitudes in terms of suitability to train as an OT, however only in terms of the nature rather than the amount of contact, when the overall suitability score was compared for the different levels of contact there were no significant differences between the groups (χ^2=4.186, df=4, p=0.381). However, having worked with a disabled colleague did give a significantly more positive suitability score (z=-2.671, p=0.008).

In terms of the main questionnaire, the nature of the contact, in terms of having worked with a disabled colleague, appears to be the key variable in determining attitudes towards disabled people.

Effects of contact on personal/professional attitudes

The respondent group for the personal/professional questionnaire were 2nd year OT students, so it is somewhat surprising to note, as Figure 6:21 shows, that 19% of this respondent group reported that they knew no-one who was disabled and that 51% had only one contact with disabled people.

Figure 6:21: **Bar chart showing the amount of contact with disabled people for respondents of the personal/ professional attitudes questionnaire**



By far the most frequent type of contact was with disabled friends, 62% of respondents reported having disabled friends. In contrast to the OT data for the main questionnaire, only 30% of this group reported having worked with a disabled colleague, possibly indicating that this group of students took the item to mean a professional colleague rather than seeing disabled clients as colleagues.

The amount of contact does not seem to have an effect on attitudes as statistical analysis revealed no significant differences between personal ATDP scores and total contact scores ($F_{3,51}$=1.7151, p=0.1755) nor between professional ATDP scores and total contact cores ($F_{3,49}$=1.1406, p=0.3420). The nature of contact, also, does not seem to have an effect on attitudes. Statistical analysis for both personal and professional attitudes for each contact variable reveals no significant differences. However, in contrast to the main questionnaire data, having a disabled family member does have a positive effect on personal attitudes (disabled family member: 140.56; no disabled family member: 135.61) and more so on professional attitudes (141.57: 134.00). Having a disabled friend also has some effect, this time on personal attitudes, with mean scores of 139.51 (disabled friend) and 133.36 (no disabled friends).

A final aspect of contact within the personal/professional study was what module the students were studying when they completed the questionnaires. The students completed the questionnaires during the 1st term of their 2nd year of study, which is the first opportunity they have for choice of which modules to study. The choice available to these students was:

1918: a social work module looking at mental health issues;

1261: a nursing module looking at learning disability issues;

1528: an OT module, taught with social work, which has a key focus of client-centred practice and has both disabled and non-disabled people as part of the teaching team.

It might be assumed that, given the nature of module 1528, this module might have some effect on attitudes towards disabled people. However this does not seem to be the case as table 6:32 illustrates:

Table 6:32: Mean ATDP scores for personal and professional questionnaires by acceptable modules studied

module	*personal ATDP mean*	*professional ATDP mean*
1528 (n=15)	131.64	136.61
1918 (n=21)	139.88	134.26
1261 (n=26)	138.50	137.15

These differences are, however, not statistically significant.

It should be concluded, therefore, that whilst contact appears to be a significant factor for the main questionnaire, when looking at other groups of OT students, contact with disabled people is a less significant variable.

The effects of age and gender on attitudes towards disabled people

Before attempting to reflect on how the data have answered the research questions set out at the beginning of this chapter, it is necessary to review two other possible key variables which might affect attitudes towards disabled people. These two variables are age and gender, these are especially important given the differences in age and gender of the various respondent groups.

Age

As Table 6:33 shows, the ages of the various year groups for the main questionnaire are somewhat different. This might mean that any differences in attitudes towards disabled people (ATDP score etc) might be due to age rather than whether the respondent was an OT student or not.

Table 6:33: Overview of ages for the respondent groups for the main questionnaire

respondent group	*mean age*	*sd*	*range*
OT students			
1st year (n=70)	21.00	4.34	18 – 40
2nd year (n=65)	22.46	3.95	19 – 41
3rd year (n=64)	23.30	3.84	20 - 42
overall (n=199)	22.22	4.15	18 – 42
non-OT students			
1st year (n=46)	23.37	6.16	18 – 41
3rd year (n=23)	26.91	8.02	20 – 45
overall (n=69)	25.55	7.01	18 – 45
total	22.82	5.13	18 – 45

Whilst there are no differences between OT and non-OT students, in terms of age, as a whole (z=-1.649, p=0.100), there are significant differences between the various year groups, as Table 6:34 and statistical analysis with Kruskal-Wallis tests (χ^2=41.717, df=4, p<0.000) shows.

Table 6:34: Results of post hoc analysis of the ages of the different year groups

comparison	*z*	*p*
OT 1st year v. OT 2nd year	-4.113	<0.001*
OT 1st year v. OT 3rd year	-5.413	<0.001*
OT 1st year v. non-OT 1st year	-2.529	0.011*
OT 1st year v. non-OT 3rd year	-4.540	<0.001*
OT 2nd year v. OT 3rd year	-2.175	0.030*
OT 2nd year v. non-OT 1st year	-0.782	0.434
OT 2nd year v. non-OT 3rd year	-2.684	0.007*
OT 3rd year v. non-OT 1st year	-2.056	0.040*
OT 3rd year v. non-OT 3rd year	-1.446	0.148
Non-OT 1st year v. non-OT 3rd year	-2.613	0.009*

** indicates statistically significant differences*

In the light of these significant differences in age, it might be assumed that age might act as a confounding variable and have an effect on the various measures within the study.

Within the main study, however, there is no association between age and ATDP score (R=0.031) nor between age and total suitability for OT score (R=0.045). Age does not seem to be related to the amount of contact which respondents had with disabled people (R=-0.133).

Within the personal/professional attitudes part of the study, the mean age for the group of 2nd year OT students was 25.26 (*sd*=6.68, range=19-47). Although age does not appear to be correlated with either personal (*R*=0.0453) or professional (*R*=0.0343) for this part of the study, age does appear to affect total contact with the group with 4 contacts being significantly older (mean age=33.28 years) than students with any other level of contact ($F_{3,59}$=4.5926, *p*=0.0059).

Finally, within the Disability Social Distance Scale part of the study the mean ages (*sd*, range) for each year group are:

1st year – 23.32 (6.64, 18-42)

2nd year – 24.37 (5.63, 19-47)

3rd year – 24.55 (5.67, 20-43).

In this part of the study, age does not appear to correlate with any item on the Disability Social Distance Scale. For the majority of items there is a slight negative correlation (e.g. overall: *R*=-0.0226), which might be expected. However, for the items alcoholic, asthma, diabetes, epilepsy, mental illness and paraplegic the weak correlation is positive, indicating that social distance becomes greater with age.

It may, therefore, be concluded that age does not appear to be a confounding variable within this study.

Gender

The usual ratio of female to male OT students is 95:5. As Table 6:35 shows, the ratio of female to male respondents for the non-OT and OT faculty groups

are somewhat different from this expectation. The proportion of female to male respondents for the other parts of the study (personal/professional attitudes & DSDS) were within the expected parameters for OT students.

Table 6:35: Overview of gender ratios for the respondent groups for the main questionnaire

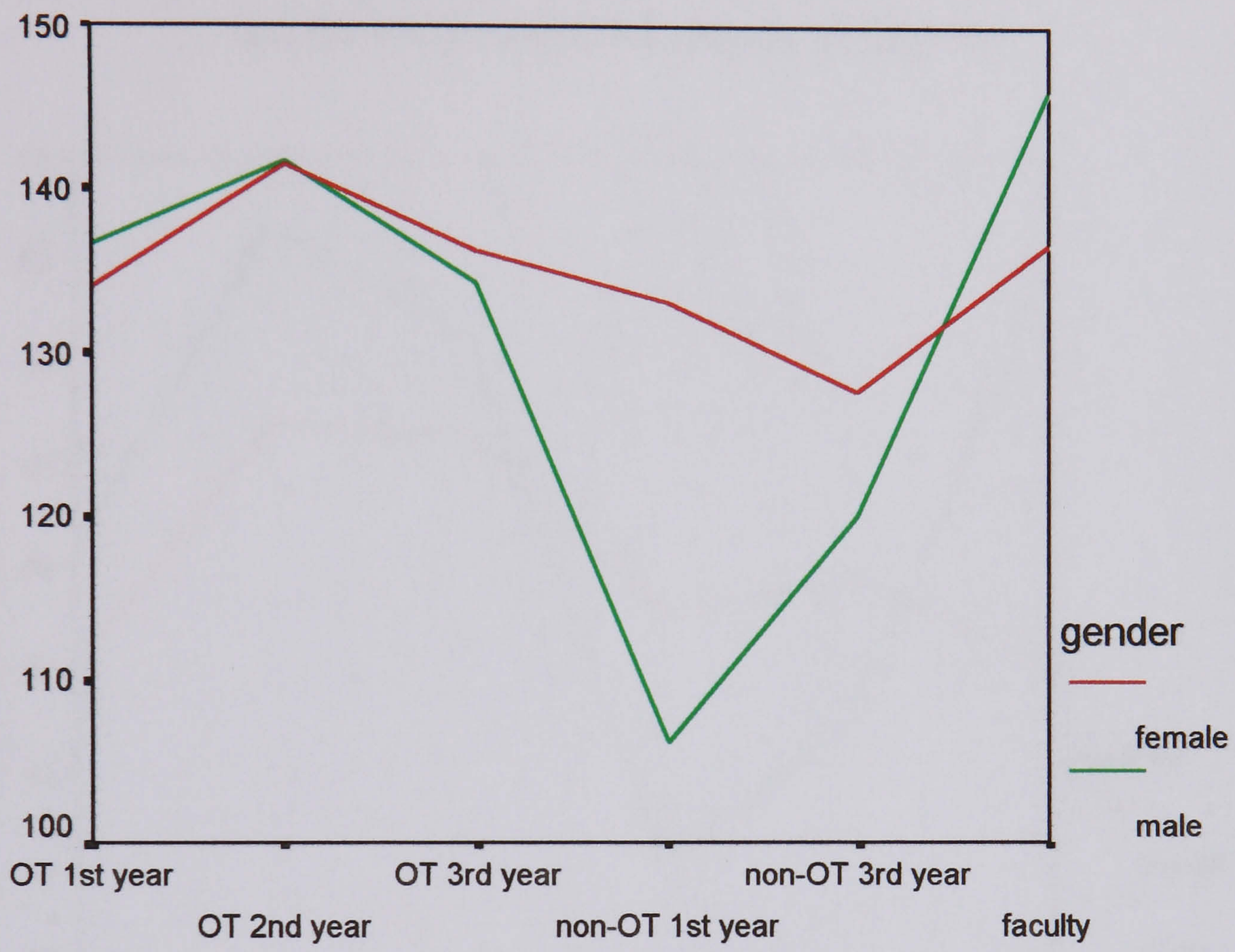
respondent group	*female:male ratio*	*% female*
OT students		
1st year	67:3	95.7%
2nd year	62:3	95.4%
3rd year	59:5	92.2%
non-OT students		
1st year	29:17	63.0%
3rd year	20:3	87.0%
OT faculty	13:2	86.7%
total	250:33	88.3%

Because of the disparity in proportions of female to male respondents, gender must be looked at as a potential confounding variable within this study.

Within the main study there do appear to be clear differences in attitudes towards disabled people between male and female respondents. Statistical analysis, using Mann Whitney U test, indicates a significant difference between the groups (z=-3.481, p=0.001). The non-OT 1st year male respondents appear to hold the least positive attitudes towards disabled

people. As Figure 6:22 shows the mean ATDP scores for this group are clearly much lower than those of the other respondent groups.

Figure 6:22: Line graph illustrating mean ATDP scores for respondent groups by gender

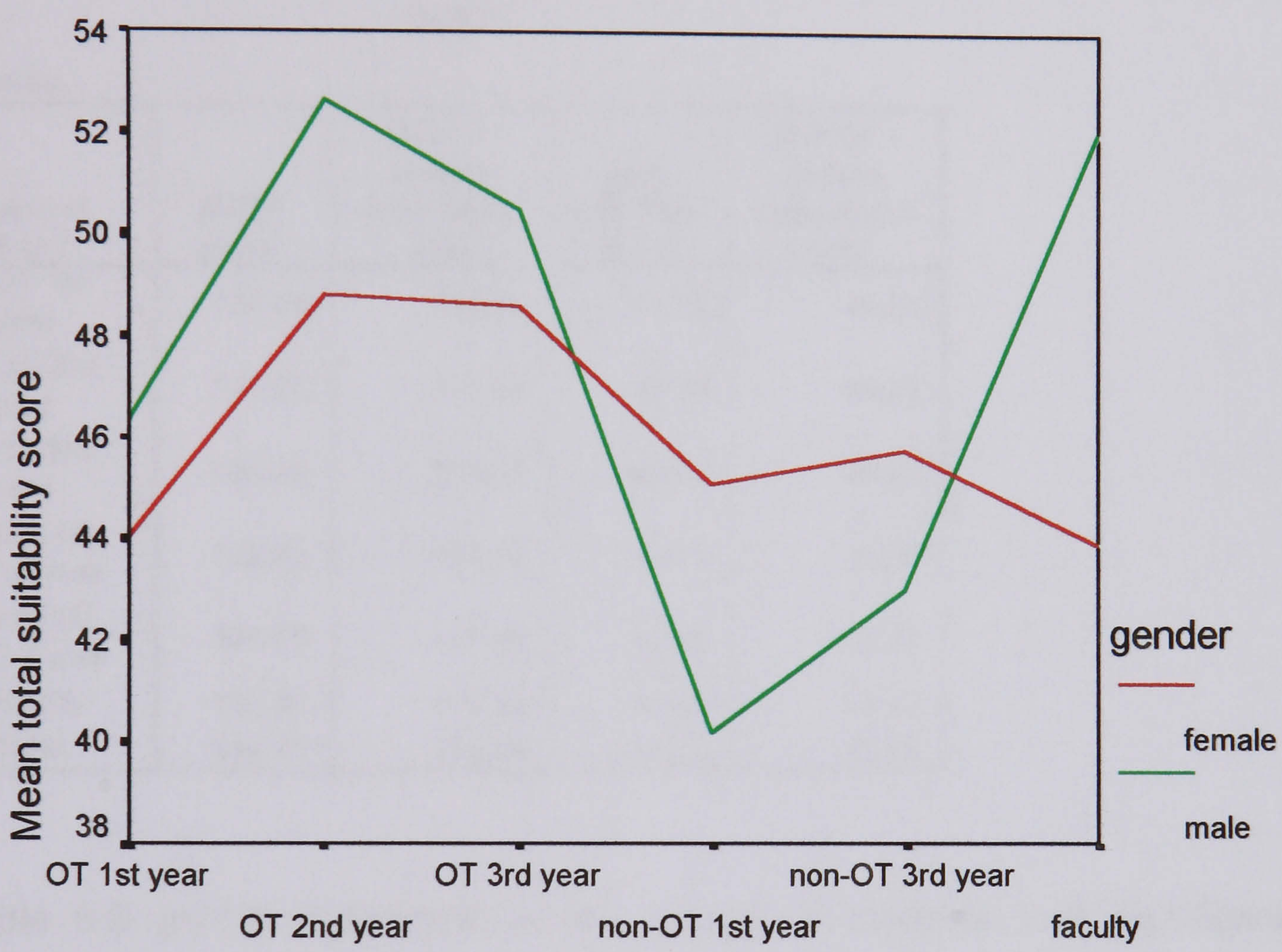


Because of the differing group sizes and small numbers in some of the groups, statistical analysis of these data would not be meaningful.

Gender also appears to have an effect on the overall suitability for OT scores. However, statistical analysis, using Mann Whitney U test, indicates no significant difference between male and female respondents (χ^2=-1.184, p=0.236). Again, because of the disparate group sizes, further statistical analysis is not meaningful. However, as Figure 6:23 illustrates, it is the non-

OT 1st year male respondents who, again, appear to hold the least positive attitudes, in terms of whether disabled people might be suitable to be OTs.

Figure 6:23: Line graph illustrating mean overall suitability for OT scores for respondent groups by gender



In the light of these findings that gender, especially with the non-OT groups, does appear to influence attitudes towards disabled people it was deemed necessary to re-analyse the data excluding all male respondents. As Table 6:36 shows, the only group to become substantially more positive with the removal of male respondents' data is the 1st year non-OT group, whilst,

interestingly, the OT faculty become more negative with the removal of the male respondent data.

Table 6:36 Comparison of mean scores for ATDP and Suitability for OT, with and without male respondents' data

Report

Mean

year of study	ATDP score	ATDP - female respondents only	total suitability score	Suit OT - female respondents only
OT 1st year	134.06	133.94	44.11	44.01
OT 2nd year	141.62	141.48	49.00	48.95
OT 3rd year	136.12	136.07	48.72	48.73
non-OT 1st year	122.93	133.31	43.29	45.26
non-OT 3rd year	126.55	127.58	45.39	45.75
faculty	137.80	136.54	45.00	43.92
Total	134.05	135.89	46.31	46.64

Table 6:6 (p219) highlighted where groups of students had significantly different ATDP sores. Re-analysis of these data excluding male respondents indicates that the differences between

1st year OT students & 1st year non-OT students

3rd year OT students & 1st year non-OT students

1st year non-OT students & OT faculty

3rd year non-OT students & OT faculty

are not, in fact, significant. Similarly, re-analysis of the results shown in Table 6:20 (p263) indicates that the differences between 2nd year OT students and 1st year non-OT students are not significant.

Thus, whilst there is still some evidence to support the notion that OT students hold more positive attitudes towards disabled people, these results must be viewed with caution in the light of the apparent confounding effect of gender upon the results. It must, therefore, be concluded that there is the possibility of a Type I error. In other words, that the null hypothesis is rejected when it is, in fact, true. However, there is evidence to support the notion that gender effects are strongest amongst non-OT students. Therefore, comparisons between the various OT student groups can be seen as valid and reliable.

In the other two, smaller, parts of the study, where the respondents were OT students only, the confounding effects of gender are less noticeable. There are no apparent differences between personal or professional attitudes due to gender. The mean 'personal' ATDP score was 137.17 (female $\bar{x}$=137.45, male $\bar{x}$=134.40, z=-0.418, p=0.676). The mean 'professional' ATDP score was 136.23 (female $\bar{x}$=136.62, male $\bar{x}$=132.60, z=-0.575, p=0.565). Nor were there differences between overall social distance scores due to gender. The mean DSDS score was 0.587 (female $\bar{x}$=0.589, male $\bar{x}$=0.514, z=-1.430, p=0.153). However, there were differences between males and females on one item of the Disability Social Distance Scale. Male respondents had significantly smaller social distance scores for 'ex-convict' ($\bar{x}$=0.410) in comparison to female respondents ($\bar{x}$=1.077).

In terms of the research questions outlined at the beginning of the chapter, how well has the quantitative data from this study answered these questions?

There is some evidence to suggest that OT students have more positive attitudes towards disabled people than non-OT students. However, there is evidence that other factors, particularly gender, might influence attitudes. The influence of gender appears to be greatest amongst the non-OT respondents. This, together with the smaller number of non-OT respondents, tends to invalidate the non-OT data. However, even if the non-OT data are ignored, there are differences between the various groups of OT respondents which are interesting.

There is also some evidence that attitudes change over time. However, whilst common sense might expect that attitudes would become more positive with time, this does not seem to be the case. The OT 2nd year group holds the most positive attitudes, indicating a move towards more positive attitudes in the middle stages of the OT course with a levelling out towards the end of the course. OT students appear to be willing to accept disabled people both socially as friends and partners and professionally as colleagues. There does, however, appear to be a hierarchy of acceptance with mental health problems being seen as least acceptable. Finally, there is also evidence that contact with disabled people as friends and as colleagues has a positive influence on attitudes. These findings will be discussed in more detail in the concluding chapter.

The evidence presented in this analysis, whilst answering the research questions, also begs a number of other questions. In the light of the multi-dimensional nature of the ATDP, the value of this tool must be questioned.

This issue will be discussed further in the concluding chapter. The evidence suggests that the effects of contact with disabled people and the stage of professional socialisation are complex. The relationship between personal and professional attitudes also appears to be complex. Perhaps the major conclusion to be drawn from this analysis is that quantitative measures of attitudes tend to take a sledgehammer to crack a nut approach and due to the subtle and subjective nature of attitudes many changes and differences will be missed. Qualitative data should provide a richer, subtler picture of the nature of professional attitudes towards disabled people.

Chapter 7

PROFESSIONAL ATTITUDES IN PRACTICE:

QUALITATIVE FINDINGS

This chapter will give an overview of the qualitative findings drawn from this study. These findings will be used to address the following research questions:

what, amongst OT students, is a 'professional' attitude towards disabled people?

how accepting of disabled people are OT students, would they be willing to share a flat with a disabled friend or work with a disabled colleague?

what does a 'professional' attitude mean in practice?

how does this 'professional' attitude develop?

what factors influence its development?

do OT students express attitudes and values which oppress or empower their disabled clients?

In order to answer these questions the findings from the cohort interviews will be presented first, followed by the findings from the 'Practice in Partnership (Disability)' (module 1528) questionnaires and interviews.

Table 7:1 gives an overview of the respondents to the cohort interviews and Tables 7:2 and 7:3 give details of the respondents to the 'Practice in Partnership' questionnaires and interviews. It should be noted that all of the cohort interview respondents were female.

Table 7:1: Overview of the demographic data and experience of the interview cohort

respondent	age group	previous experience	1st year fieldwork	1528	2nd year fieldwork	2nd year acceptable modules *	3rd year fieldwork	3rd year acceptable modules *
1	20-24	worked with disabled children	mental health - acute admissions; stroke rehab unit	no	orthopaedics and elderly assessment	1523, 1235	profoundly deaf people with mental health problems and challenging behaviour	1527 1521 1520 1016
2	25+	exercise teacher, no experience with disabled people	community mental health *respondent withdrew from training following 1st year fieldwork*	-	-	-	-	-
3	20-24	variety of jobs prior to training, contact with disabled people through community activities	physical - general & YDU [2]; mental health - long stay	no	learning disabilities	1523 1520	physical: HIV/AIDS & paediatrics	1526 1525 1519
4	18/19	year out, working as OT/PT helper, contact with disabled people through RDA	elderly physical day centre; severe learning disabilities day centre	no	long term psychiatric disability in the community	1519 1520	physical: neuro rehab	1527 1520 1016
5	18/19	contact via Gateway, Mencap, playgroups	physical - elderly, strokes, hips; mental health - long term care	yes	physical medicine - out patients: light/heavy workshops, strokes, head injury, MS, hand, orthopaedics	1525 1520	emi [1]: day hospital and community	1527 1523 1522 1518
6	18/19	year off, working as a care assistant in residential home for children with profound handicaps	elderly day unit; emi [1]	no	physical, mainly stroke	1525 1261	psychiatry - chronic, long term patients	1527 1520 1016
7	18/19	BTec social care - placements with mentally and physically disabled people, mentally handicapped uncle	acute psychiatry; elderly physical day hospital	yes	physical rehab service	1520 1523	emi [1]	1527 1525 1016 1521

8	25+	auxiliary nurse, mainly with the elderly, OT assistant [mostly with elderly patients]	stroke rehab unit; learning disabilities [mainly in the community]	yes	social services	1523 1521	psychiatry - medium secure unit	1527 1525 1520 1016
9	20-24	previous degree study, CSV helper for student with brittle bone disease	rheumatology learning disabilities	no	child psychiatry *[failed]*	1520 1525	physical - community hospital & YDU [2] [repeat psychiatry placement also to be completed]	1527 1521 1519

NB: *emi [1] - elderly mentally infirm*
YDU [2] - young disabled unit

** see Appendix 1 for details of 2nd & 3rd year acceptable modules;*
when respondents are quoted in the text they are referred to by their year of study and then their respondent number,
e.g. 1:3 is respondent 3 in her 1st year interview.

Table 7:2: Demographic information from the 'Practice in Partnership' questionnaires

year group	*number of respondents*	*number taking the module*	*% response*
1993 [cohort year]	13	21	62%
1994	9	25	36%

Table 7:3: Overview of respondents to the 'Practice in Partnership' interviews

respondent	*age group*	*gender*
1528:1	18/19	f
1528:2	18/19	f
1528:3	20-24	f
1528:4	20-24	f
1528:5	25+	f
1528:6	25+	m

Each of the interviews was transcribed in full. Each respondent was given a copy of her/his interview transcript and asked for any comments or corrections, none were received. The transcripts were then organised so that the responses to each theme were together. The researcher then immersed herself in the data, reading and re-reading each section. Broad analytic categories were developed for each of the interview themes and the data pertinent to that theme were coded. The categorisation and coding were summarised to provide an 'audit trial' (DePoy & Gitlin, 1994: 235). The transcripts and analysis were then given to a colleague who reviewed and audited the work and confirmed the interpretations. Thus helping to ensure the credibility of the research and its findings.

Definitions and images of disability

As the starting point for the assembling of a picture of a 'professional' attitude towards disabled people, it would seem appropriate to begin by looking at

how the respondents define and describe disability, and to explore whether, and how, these definitions and images change over the three years of their degree in occupational therapy.

When asked how they would define disability, all of the 1st year students mentioned problems that the individual had or parts of the body that did not work. One respondent said:

> *I think that now we've done things like trying to cook a meal with one hand it's really easy to say 'if you want to know what disability is just try yourself, do things with your eyes closed' or whatever, that's a really good way [1.6].*

The overwhelming flavour was, what Oliver (1990: 1) terms, the 'personal tragedy model' of disability. 4 respondents emphasised that physically disabled people were 'just the same as us', this was usually their opening remark, followed up by 'but they have a problem'. One respondent illustrates this by talking about how she would explain disability to her children:

> *I've always tried to get through to them what that person feels like, and I've always said what that person wants more than anything else is to be the same as you and the same as me, and not to feel sorry for them, but to remember that they are just like any of us, it's just that they have their disability and there are some things that they can do and some things that they can't [1.8].*

A couple of people mentioned the idea of not being able to fulfil social norms or expectations:

> *well if it's like a physical disability, it's .. well physical, but a lot of it can be from society, and we create their problems for them ... we actually define what is acceptable and what is not, so therefore with things that might not actually be a problem to that person, we tell them that it is a problem to them [1.1].*

When the students were interviewed during their 2nd year, their definitions were rather more diverse and a number of themes emerged. Some respondents still spoke of something being wrong with the person, although they spoke of 'impairment' rather than 'something wrong'. The idea of function (a very OT concept) was common, disability was something that stopped you doing things. The emphasis was on the person first and then the disability. But as well as the 'personal tragedy' approach, the social model of disability was creeping in, 5 respondents mentioned that it was to do with society's attitudes or ideas of disadvantage:

> *things that make people scared ... of interacting with them [2.6]*

and

> *generally, where somebody is unable, for various reasons, to perform activities as an able bodied person would, they may be at a disadvantage or they may not, depending on their situation ... but with disabilities there's always the underlying problem anyway, so without that problem society wouldn't be a problem either [2.9].*

The personal tragedy and the social models appear to be mixed, but with the personal tragedy views being expressed first and, therefore, it could be assumed that these are the predominant ideas.

By the time the respondents were interviewed in their 3rd year, their definitions were almost totally focused on 'function', and being able to do things normally:

> *somebody who isn't able to function at a normal capacity, like a normal being, you or me [3.4].*

There were also frequent references to impairments or deficits:

> *it can be a loss, it can be .. if you're born with a disability then it's not a loss .. because that's what you were from birth so you've never experienced anything different, so it's not a loss but you're not as able as able-bodied people, so you do have a ... a deficit, which is slightly different to a loss, 'cos you're still in the same state, it might not be a loss, it might be a disability were you're not .... perhaps can't do things in the same way that you used to do them, perhaps have to compensate in other ways, but you might not have totally lost that .... action or ... you might have to do it in a different way, so you might not loose the ability, but you have to do it in a different way ... [3.6].*

These functional and deficit based definitions appear to draw heavily on a personal tragedy model of disability, implying that this group of OT students have not moved from an oppressive model of disability.

However, one respondent demonstrated a sound grasp of the social model definition and used 'disability' as something societal and clearly different from impairment:

> *it's about the person, to do with the person's interaction with the environment, so it's not personalised to the individual, like impairment would be, its more a social, environmental issue [3.8].*

Although not asked specifically about whether their definitions had changed, some of the respondents mentioned that their definitions had changed, or not, over the three years. Two of the respondents felt it had become harder to define disability:

> *because I think my definition's .. slightly changed, but I still feel that everyone has a disability, no-one is exempt from that ... the environment effects it, the person's mood effects it, a person's disability isn't just a physical thing, so my perception has changed [3.3].*

One respondent hoped her definitions had not changed over time. They, in fact, had not. Over the three years the key focus of her definition remained 'not being able to function normally'.

For the majority of respondents their definitions had changed. There appears to be a gradual evolution of definitions from 'just the same as us' but different, to a more functional definition. It is interesting to note that whilst the comment 'they're just the same as anyone else' was common in the 1st year definitions, it was not mentioned at all in subsequent interviews, possibly indicating a

greater understanding of some of the broader issues within disability and particularly disability politics. However, the emphasis on function remains an individualistic notion of the problems of disability and does beg the question of how far the students have moved in terms of holding empowering rather than oppressive attitudes towards, and views about, disabled people.

In order to gain as broad a picture as possible of their ideas about disabled people, the respondents were asked to talk about and describe someone they knew who was physically disabled. It was thought that by doing this the researcher would get a clearer picture of who the respondents saw, or categorised, as disabled, as well as being able to explore their contact with disabled people.

The majority of respondents talked about friends who were disabled, although a number also mentioned family members and two respondents talked about people they had worked with in care settings (e.g. Riding for the Disabled; as a house parent at a special school). The ways that the respondents talked about the different groups of people were interesting and highlighted contrasts between friends, family and especially working relationships. When taking about friends who were disabled almost all of the respondents saw the disability as secondary to the person:

> *.. she's 26ish, very happy, doesn't...it took a long time before I actually thought of her as disabled, I mean the only reason that makes me think of her as disabled now is 'cos she actually called herself disabled,*

otherwise I still don't think I would...because I don't see the disability first... it's something that I feel very strongly about, I think a lot of people who see disability first then use their stereotypes to imagine what the person is like, and then you don't get to know the person, you get to know the disability [1.1].

One respondent had a rather different interpretation of disability:

> *I've got a friend, who is diabetic, and I would class him as physically disabled ... because he's not a good diabetic, he doesn't behave himself .... it makes him physically ill .... but to me that's physical just as much as having an amputation [1.3].*

When talking about relatives who were disabled two themes emerged. Again there was a focus on the person not the disability:

> *... my mother .. she's got an arthritic shoulder and she broke her ankle and then her wrist....taking the definition of disability as some impairment and you lose some degree of function, then definitely my mother can't do an awful lot with her arm, but no way would I think my mother is disabled [1.2].*

However age was also equated with disability by a number of respondents:

> *I don't think I know anyone else who is physically disabled .... apart from my grandparents .. they're not wheelchair bound, but my grandfather can hardly walk because he's got really bad hips, I think he needs a hip replacement .... [1.6].*

Note the use of the disablist terminology in this quote. Disabled people are seen as wheelchair *bound*, rather than as wheelchair *users*.

The comments of the two respondents who talked about physically disabled people they had worked with, however, were very different from the previous comments. Their responses were much more clinical and focused on the disability and the problems the individuals had, almost to the exclusion of the person with the disability:

> *at [name of hospital] you learnt fairly quickly to look at the disability, and then you start looking at the person... that sounds really awful .... but coming into a medical profession, you immediately see what the problem is... like if I'm walking down the street and I see someone and I think what might be wrong with them. I've seen therapists at both places I worked ..... saying to me 'there's a total hip up on such a ward .... you go and finish them off' [1.4].*

The marked contrast between the friend/family comments and those above highlight very vividly the perceived contrast between personal and professional attitudes towards disabled people. These contrasts will be explored in more detail later in this chapter.

The question was asked again in the 3rd year interviews. The range of people described was similar to those of the 1st year interviews: friends, family and work contacts. The main focus was, again on the person first and the disability second. The two respondents who focused on the personal tragedy

and problems of disability did so again. One respondent, who was very influenced by her Dissertation research, talked about the social oppression of disabled people:

> *I interviewed lots of disabled people, and my thinking has probably changed, 'cos of the people that I interviewed, who were very active and fighting against ... the discrimination, but I suppose their disabilities, to them, weren't anything physical at all, it was society, so that was the disability regardless of the fact that they were wheelchair users, or blind, they didn't see .. what was wrong with them as a disability at all, it was .. the society that was disabling them, ... [3.5].*

Finally, one respondent thought that everyone was disabled:

> *..... everyone I come into contact with ... I mean .. it's ..... yes .. everyone has some kind of disability, I need glasses at the moment, from reading so much and using a lot of computers, that's a disability, to me, because I'm having to use an artificial aid of some kind [3.3].*

In the second year interviews, rather then talking about someone they knew who was disabled, the respondents were asked how they reacted when they saw a physically disabled person in the street. This was to explore with the respondents the idea of a 'professional gaze', whether they looked at any disabled person though the perspective of their profession.

The majority of the respondents did acknowledge their professional gaze, either explicitly or as a follow up comment to saying they never really noticed disability:

> *... I don't know, I don't think I often see it, perhaps that's because I'm not seeing someone that is disabled, I don't see the wheelchair, the white stick or the bits and pieces, until its drawn to my attention, by someone either mentioning it……*
>
> *MCT [interviewer]: so you haven't developed this professional curiosity, of thinking 'I wonder what they've got'?*
>
> *..... on television I do, I suppose its because on television I don't see them as much as people, I know that sounds strange, but there's not that personalised feeling, so then I will tend to think 'he's got that', or 'they could have that', but not really in the street, I think it depersonalises them, and I don't like that [2.1].*

The respondents who, particularly, responded with 'I wonder what they've got' as their first comment usually reflected a degree of embarrassment at this:

> *... I wonder what they've got ... wonder what they're doing there, .. nice wheelchair ... if I see somebody walking down the street with a limp, and I'll look and think 'I wonder what they've got', or 'he's ... circumducting his hip, or he's not flexing his knee'... yes. I do think 'what have they got', or 'the zimmer frame's too short, or too long', I do, but I think that's part of being a therapist, part of improving your observational skills ... we only get a term a year to go out and do the stuff, so when you do come back and you see a slight opportunity for*

having a look at somebody who is disabled, its, like, have a look ... I do look, I know I shouldn't .... it's like staring, well not staring, but, like, thinking ..... em ... I think everyone else feels embarrassed about me doing it ... but ... it doesn't matter that you're staring, 'cos they have to put up with it the whole time, everyone in the street is at least taking a double glance, and that's all I'm doing, and I'm gaining something from it ... it sounds really bad [2.4].

The embarrassment was, as can be seen, tempered by the excuse that as OTs they were being trained to observe and that they know about all these conditions so it is, somehow, natural to be curious. The effects of the increased knowledge and insight the course has given them is reflected by one respondent who commented that she felt she had an understanding and an empathy for any disabled person she saw in the street:

.... just think that they are equal people, ... I just don't think of them as being any different .... I think, I've met people like you... I think I have empathy now [2.6].

The findings presented in this section have attempted to begin to build a picture of the respondents' definitions and images of disability and disabled people. It is interesting to note that whilst on a personal level the respondents tended to focus on the person first and the disability second, when talking about disability in general the focus tended to be on the problems of the individual. This is particularly noticeable in the ways the respondents' definitions of disability evolved over the three years. In the first interviews the

focus was on problems and functional issues, in the second interviews functional problems and issues of social oppression were evenly mixed, but in the third interviews the majority of the respondents had returned to the functional problems and issues to do with deficits. The respondents began their professional education with a personal tragedy focus, they moved towards a social model approach in their 2nd year, but returned to a personal tragedy approach as they neared the end of their formal professional education. These findings echo, in some way, the results of the main questionnaire outlined in the previous chapter. The 2nd year OT student group held the most positive attitudes towards disabled people. The interview cohort also appear to demonstrate this more rounded view of disability in their second year interviews, with a move back to more individualistic, personal tragedy views in the third interviews.

The changes in views and the return to the focus on functional problems and a personal tragedy model may, in part, be due to a 'professional' perspective. The contrast between personal and professional views has been highlighted in the descriptions of someone who is disabled and in the development of a professional gaze. Both of these show clearly that when the respondent knows the disabled person, the focus is on the person first and the impairment or disability second or not even noticed. However, when the person is seen in a professional capacity, or is an anonymous disabled person on the street or on television, the focus is on the problems and the impairment. Thus we might, tentatively, conclude that, whilst OTs as

individuals do not hold oppressive (personal tragedy) attitudes, OT as a profession tends to promote an individualistic, personal tragedy and, possibly oppressive, image of disability. The contrast of personal and professional attitudes will be explored further in the following sections. The complexities of oppressive and empowering perspectives will also be discussed and will be reviewed thoroughly within the concluding chapter.

'Personal' attitudes: disabled people as friends and colleagues

As part of the first year interviews respondents were presented with a number of scenarios involving interactions with disabled people. Two of the scenarios focused on personal relationships with disabled people as a way of further exploring the respondents' personal attitudes towards disabled people. The scenarios involved sharing a flat with a disabled person and working with a disabled colleague.

Sharing a flat with a disabled friend

Whilst all of the respondents felt that they would expect the disabled friend to do their fair share of the chores, within their capabilities, there were interesting variations in how the respondents would deal with helping the person if there were things they were unable to do. These differences probably say a great deal about the different respondents' personalities, but may also have implications for the ways they function as health care professionals. All of the respondents said that they would help if needed, but they were equally divided as to whether they would help only when asked:

... well if they needed help then I would give it

MCT: would you wait till they asked or ...

I would wait till they asked [1.8];

helping, but only if the person was really trying and really needed help:

I would like to evaluate the situation, I think the more contact you have with people, I think you then become able to evaluate whether someone genuinely needs help or whether someone may be in difficulties but doesn't really need the help [1.1]:

..... as long as they helped themselves, it would make me cross if they wouldn't help themselves [1.7];

and assuming that they would know when help was required:

it would just come naturally, I think, they, hopefully they wouldn't have to ask for help, you'd just know when they needed help and you'd just do it [1.6].

One respondent commented that she did not see herself in a 'caring' role, nor that she would be very good at it:

.....it would depend on the degree of help... I don't think I'd make a very good carer to be quite honest ..... I've just never seen myself in that role ..... oh, I can care, but not as a carer, doing things for people that they can't do, so feeding them, washing all those sort of things, that's something I wouldn't particularly be good at [1.2].

Interestingly, this respondent subsequently left the course, having decided that OT was not for her.

The implication, which was apparent in a number of comments, that someone should only be offered or given help if they were showing evidence of trying to help themselves, has interesting implications for how these students might view, and judge, the efforts of their disabled patients to do things for themselves. If the patient chooses not to attempt an activity, for whatever reason, will these students judge that patient as less deserving of therapeutic help than the patient who does whatever s/he is asked to do? These may be the first seeds of oppressive practice. The students' responses when presented with a scenario of a patient who chooses not to get dressed will be discussed in the next section.

Working with a disabled colleague

The second scenario, which focused on 'personal' reactions to disabled people, asked the students how they would react to a colleague who was disabled. Perhaps not surprisingly, all of the students said that they would not find it a problem working with a colleague who was disabled. Two students did, however, qualify their responses with:

> *as long as they were capable, like anybody else, of doing the job, and were a nice person [1:9].*

Although two other students indicated a sense of respect for the achievement of qualifying as a professional in spite of a disability:

> *it might make me think well I'm glad that they had the courage to actually go .. 'cos I mean, society generally restricts disabled people's entry into professions like that [1:1].*

One student had worked with a disabled colleague and her response indicated a somewhat less than positive response:

> *it wouldn't bother me ... like at [name of hospital] there was this woman who had MS ... and I didn't realise ... and I held the door open for her once, and probably gave her a patronising look, or something, ... and then walking on down the corridor and the therapist I was with said 'well you know she's a member of staff' and I thought oh God.. and things like when she rang up the department and she spoke so slowly ..... and at times you'd be sitting there and thinking 'I've got a hundred and one other things to do, speed up a bit' .... and you get a bit frustrated ..... but I think I'd cope, I mean you just accept them for what they are [1:4].*

Another student demonstrated a conflict between disabled people as people to be 'helped' and how one should respond to a colleague:

> *..... seeing we're going to be working with people who are disabled .... I don't really know, I haven't worked with anyone who is disabled as a colleague, so ... I want to help people who are disabled because it's just something that I want to do, ... I can't really say, its quite hard to know how you would feel working with someone [1:6].*

When asked about how they would assist the colleague if s/he needed help, all of the respondents talked about asking the person what they needed and the need to negotiate what was appropriate:

.... well, if you were working with them then you'd get to know them and you would just discuss it, and find out, and they would ask if they wanted you to help or whatever, I would presume that's what they would do [1:8].

These responses are an interesting contrast to how the students responded that they might help a disabled flat-mate. The nature of the colleague relationship appears to be such that helping without being asked is not seen as appropriate:

talk to them, say if you do need help I'm willing, I don't want to tread on your toes .. and like 'mummy' you.. yes I'd just discuss it with her [1:1].

A colleague is, by virtue of her/his professional training, competent:

... they've done their training the same as any other person and they've got through that training and that means that they can do the job just as well as any of us [1:8].

This notion of competence, therefore, implies equality and that help is negotiated rather than imposed. This is in marked contrast to the response to friends or, as we will see later, patients, where help or intervention can be imposed or at least given without asking whether it is appropriate. The apparent attitudes towards colleagues who are disabled appear to be the most positive and equal, where the disability is truly secondary to the skills of the individual. This has implications for professional training and professional relationships, where the notion of disabled people as colleagues when dealing with the problems of disability needs to be fostered and encouraged.

'Professional' attitudes in practice

The exploration of issues related to 'professional' attitudes towards disabled people formed the main focus of the interviews over the 3 years. Students were presented with a scenario of a patient, who had a long-term disabling illness such as rheumatoid arthritis (RA), who they had gone to see to carry out a dressing assessment (a common and routine OT task) and the patient had refused to get dressed. Around this scenario issues to do with definitions of independence; empowerment; priorities and choices; and the nature of successful treatment were also explored.

What is independence?

The goal of OT is often, as we have seen, described as helping people to become independent. However, as we have also seen, there is a potential conflict between the medical/rehabilitation concept of independence as normal functioning and being able to care for oneself and the social/ independent living model concepts of independence as choice, control and participation in society. This conflict was apparent in what the students said when talking about independence as their treatment goal. The majority of students talked about independence in terms of self-care and function:

> *self care, mobility, things like that, being able to prepare themselves a meal, preferably being able to use the cooker and the kettle, ... and safety, that they are not in danger, of hurting themselves or putting themselves into a position where they could be hurt by other things ... [2:6;]*

..... to do as much as you can for yourself [2.7];

a level of functioning, both physical and psychological [2.3].

However, the issue of what the patient/client thought was appropriate also came into some definitions:

function effectively for themselves, whatever they see as adequate ... being satisfied with what you are actually being able to do [2:1];

make choices, and do the things they want to do, and my job is to try and organise that for them, to try and help them to achieve that, as long as it's not totally unrealistic, as long as it's a realistic aim [2.8].

However, a thread that ran through the discussion of independence, and empowerment, was the expectation of normality and that the patient/client should strive to be like everyone else:

so that they can do whatever they want and whatever everybody else can do [3:1];

as an OT, you would think - independence, they've got .. it would be nice for them to be able to dress themselves and feel good about themselves if they can do that themselves, but that is only your opinion, they might not feel like that at all [3:7].

Issues of choice were apparent in the discussions, but for some students only came into their definitions when they talked about independence for themselves:

just having the choice to do what I really want is independence, and being able to do things I want to do [2:6];

to be able to have choices ..... to do the things that I want to do, not to be restricted [2.8].

But even these definitions were tinged with functional ideas:

..... being able to get up, wash myself, get dressed, make myself a cup of tea, if I want to make myself a cup of tea .. going out when I want to, talking to who I want to talk to ..... making my own choices really [2.7].

This emphasis on function rather than choice from students who have seen OT in practice and, therefore, must have seen functional independence used as the goal for OT interventions does seem to imply that the ideas underpinning OT in practice are oppressive rather than empowering.

What is empowerment?

Students, by the time of the 3rd year interviews, had been exposed to the concepts of empowerment and patient/client choice within a number of modules (e.g. 1513, 1528, 1597). The ideas, which underpin empowerment, are choice and giving the client the power to make her/his own choices and decisions. These were the ideas which the students focused on when defining and discussing empowerment:

.. giving the person, who's come to you for the service, the opportunity .. to .. explore, express ... their needs, their wants, their wishes ... and enabling them to make decisions [3:3];

... enabling that person to have power and control .. over their life, getting things going how they want them to, so that they can do

whatever they want to and whatever everybody else can do ... and working towards that as much as possible [3:1].

Empowerment was also seen as giving clients skills, although, at times this could be conflated with functional independence:

..... giving people the opportunity, the encouragement and the skills to do it themselves, I'm all for empowerment, its nice to be able to let somebody do it for themselves rather than you doing it for them [3:7];

.. it's giving or teaching skills to .. an individual so that they are able to do activities or carry out tasks that they weren't able to do, because they didn't have the skills .. or perhaps, aids and equipment, they didn't have those [3:6].

Some students recognised that empowerment was not always easy for the therapist either because it was uncomfortable to be challenged, or because they were reluctant to acknowledge that a patient with a chronic illness might be more of an expert and have more knowledge than they, the professional expert, might have:

I don't think we like to hear people complain, I don't think we like to give people the opportunity to say 'I don't want that' [3:3];

yes, as long as it's done in balance ... 'cos it's no point giving the people the power when they haven't got the expertise .. I have trained for 3 years [3:9];

nor for the client:

sometimes it might not be possible to become empowered, because of the way you feel about yourself, but we can help, if people want to be

empowered, again some people want to be, or like to be told what to do and don't want to get involved they just want to be 'treated' [3:5].

However, some students saw empowerment as mainly a theoretical notion which did not help them as therapists:

..... [name of module leader] ..... it's very much one of these words, like holistic, which says everything, but how much does it actually mean ... and everyone goes around saying they want to empower the client into being able to do this .. to give them the opportunity or the chance, the choice ... yes, I guess it is a word that I put in my essay the other day or I come across when I'm revising .... but I think it's one of these things that OT .. is getting down to lots of big words ...'cos we feel we should be more professional, because at the end of the day it's all common sense type stuff [3:4].

DePoy and Merrill (1988) found that students could articulate the values of OT, but were not always clear of their value and usefulness. The same may be said of the students in this study. All of the students could articulate the concept of empowerment but not all of them, as we will again see later in the chapter, could put these ideas into practice in terms of real patient choice.

Before we explore the students' response to the patient scenario we need to look at one more theoretical concept. Throughout the course, students are exposed to both the medical and social models of care and disability. But, as with empowerment, these might be seen purely as theoretical concepts. The

final theoretical concept to be discussed is how relevant the students thought the social model of disability was to their practice.

The social model and OT

The students would have had the opportunity to discuss the social model in a variety of modules, including 1504, 1528 and 1514. Discussion of the social model focused on two issues: whether the students could define and articulate the social model; and then, whether they felt it had any relevance to the practice of OT.

Only three students were able to articulate clearly what the social model was:

> *it's bringing in social issues, it's saying that disability isn't just about the individual and what's happening with that person, but that a large part of disabled people's problems are the problems that they encounter in society, and that's .. often their main problem [3:8].*

The remaining students saw the social model in terms of holism and looking at the person in their social environment:

> *mm .. it's looking more at the consequences of their handicap, going further than the just the hospital bed, or .. the wheelchair, looking at the environment, the family .... perhaps work, leisure interests, you're not actually looking at diagnosis or the .. what's actually wrong with the patient, you're looking at what they can do and how you can enable them to do it, in their own setting, in their house or wherever it may be,*

.. so it's looking at the person in relation to the world, not in relation to his illness [3:6];

The reaction of a number of students was confusion and being unsure that they should know about the social model:

... oh, gosh .. should I have an understanding? [3:1];

MCT: something that we talk about is the social model of disability .. mm ...

MCT: is that something that you're familiar with?

..... it could be ... how people see people with disability? [3:4].

This uncertainty was also noted by one of the students who had a clear understanding of the social model:

I've come back and done some modules that were very medically orientated ... and I've had quite a lot of conflicts within modules .. with my peers ... we don't actually cover much in the Course on the politics of disability .. I don't think they're all that clued up ... we haven't thought about how the individual feels about being discriminated against ... [3:5].

As a result of these confusions it was not surprising to find that students had varied views on the relevance of the social model for OT practice. The students who had a clear understanding of the social model also had an appreciation of how the medical and social models influence OT practice:

I still think that as OTs we're trained to look at what is wrong with somebody ... but then I look at what problems they face with everything ... at home and society and whatever ... I wish the social model was

fully used, but it's not, we're still very medically orientated, but I think knowing the social model and believing in the social model will help quite a lot, because even though I will look at people's physical problems I won't just look at the physical problems, it won't stop there ... if you're working in a place that is very medical model minded, they're not going to be looking at the environment and the social situation, and things which are important, because people are a lot more than just a body .. they've got more components, so to speak, and because you've got something physically wrong with you, that might not be a problem but the fact that you can't go into your favourite shop might be a problem .. [3:5].

Although, being able to articulate the social model does not imply agreeing with it or feeling comfortable using it as an approach to practice:

I must say I quite like the medical model

MCT: why's that?

because ... I think the best way to deal with disability is to get rid of it, if at all possible, and although it's not possible, I think that's the first thing you have to look at ... and I don't like the conflict between them, I think that you should work through the medical model as far as you can and then move on to the social model and always keep looking between the two [3:9].

The remaining students tended to discuss the holistic nature of OT practice, but still focusing on the problems a disabled person might have within their environment:

I think, when you think about the social model, it's much more a community thing, yes .. there is a role for OT in the community ... but I was thinking more of .... by that stage .. if you're able to go out and be seen in your wheelchair .. or having a nervous attack, or something, in the street, you're quite ... able to cope with most of the OTish things [3:4];

whilst acknowledging that the OT has a role within a patient focused medical approach:

> *but I think we still need to take into account some of the things you might in a medical approach, we probably need an approach in the middle [3:7].*

The students' rather limited understanding of the social model is in marked contrast to their grasp of empowerment. There appeared to be a minimal grasp of the issues of oppression and inequality which underpin the social model. The focus appeared to be on holism and seeing the person within her/ his social context, but still seeing the problems as those of the individual rather than imposed by society, and, thus, reinforcing the oppression, inequalities and disempowerment experienced by disabled people. However, 3 students could articulate these issues which begs the question what knowledge or experience have they had which the other students have not had, or have failed to draw on? The next section will deal with the application of theory to practice and whether students allow patients choice in how they choose to be independent.

Dealing with a patient who chooses not to dress herself

As we have seen, the students were able to articulate the concept of empowerment and ideas of patient/client choice. Their concepts of independence as a treatment goal, however, tended to highlight functional independence and their conceptualisation of the social model of disability tended to focus on the patient/client within her/his environment, implying that the problems of disabled people focus mainly within the person rather than within society. These discussions were, however, in the abstract. How much choice and empowerment were the students prepared to give in practice?

When presented with the scenario of a patient with an ongoing, possibly deteriorating condition, like RA, whom the student has gone to do a dressing assessment with and the patient says 'no', what would the students do? For the majority of 1st year students, their first response was to persuade the patient to get dressed and if that did not work to go back later:

> *if it's .. they're embarrassed because of the disability then talk to them and say 'you shouldn't be, it's something you've got to cope with and if you persevered with it, it won't be as bad', but if it's because they are just fed up or tired, or fed up with life, then I'd say 'fair enough, we'll do it another day' [1:5];*
>
> *my priorities as a therapist would be to get the patient dressed and out [1.4].*

Only 4 people actually said they would ask why the patient did not want to get dressed:

..... say why don't you want to get dressed .... if they don't want to and they obviously want somebody to do it for them for some reason, and try and find out what that reason is ... [1:2].

When told that the patient had other priorities for her limited energy, the group divided into: the majority, who said that getting dressed was normal (unless the patient happened to be elderly) and so the person had to get dressed and their job as an OT was to find ways of making it easier:

... if you don't dress yourself, you will be very limited, because you can't do many things without your clothes on, so it would be a case of having to if you want to be perceived as anywhere near normal then you've got to put your clothes on [1:5];

I don't know that I'd let her not get dressed, but I think I'd encourage her, even if it's just to put her stockings on, ... it depends where she is, if she's in her own home then it's acceptable for old people to be not dressed, [1.3];

.... perhaps explain to them that if they didn't do this dressing practice, and it got to a stage when they got worse and then it might be totally impossible for them to get dressed .... or that it might get harder, and the quicker they learn to get themselves dressed then the less energy they'd probably be using, because they'd find a technique that might help them do things [1:7];

and those who felt it was acceptable not to get dressed or to have help to dress and their job might be to facilitate this:

try and talk to them try and explain the purpose of it ...

MCT: what if they said 'OK, I'll get dressed for you, but I'm never going to do this, because I have finite amounts of energy and I'd really rather use my energy for doing something else. It takes me 2 hours to get dressed in the morning and I'm exhausted. But what I'd really like to be able to do is be able to cook a meal for my children'. What would you do then, what happens to the dressing?

that's more important, and especially if they've got the motivation to do something else, it's not that they don't want to do anything, then that seems to make sense and to do what they want to do, it doesn't really matter if they don't get dressed [1.8].

This quote seems to illustrate a rather sophisticated difference in reasoning, between someone who can't be bothered and someone who could but had other priorities and that the student's expectations and approach would vary depending upon the perceived motivation of the patient.

By the time of the 2nd year interviews, the students had experienced 2 terms of Fieldwork Placement as well as 2 further terms of academic modules. Had this experience made them more client-centred, more flexible in their approach, or were they still focusing on functional independence as the goal of their interventions? The responses were evenly divided between functioning 'normally':

... well, point out to her that she's got to be able to cope, she'll want to get home, so you can say, like, 'if you want to go home, we can't let you go until we think that you are going to be able to cope at home' ...

you've got your, sort of, classic adaptations and what have you ... maybe spending a little more over it ... or wearing different things, like, maybe, wraps that are a bit easier.... [2:4];

'cos some people don't like getting up early, you might be seeing her at 8.30 and she's not used to getting up till 10, so if you come back later and see if that helps ... you could suggest that she could just do some things, but maybe say 'you do so much and I'll help you with the rest, so that you could conserve energy' ... so that she is actually doing something towards it, but not everything, which might make her really tired, ... maybe alternate the things I do with her and the things she likes doing, that she wants to save her energy for, and then she might be more co-operative with the things she doesn't like doing ... it's just more socially acceptable for her to get up and washed and dressed in the morning, ... I certainly feel better if I get up, washed and dressed [2:6];

and facilitating the patient to achieve her goals:

if she doesn't want to get dressed she doesn't have to, that's her choice ... if she didn't want to get dressed than she shouldn't have to .... I would find out whether this was a, sort of, normal behaviour thing for her at home because if she doesn't get dressed at home then why should she have to get dressed in hospital ... if she doesn't see it as important in her life, if she is quite happy for someone else to come in and give her a hand, or if there is someone else who can give her a

hand, then we'd organise that, or try to get her to organise that ... if she couldn't then do it myself ... [2:3].

It would appear that for a few respondents a taste of reality and clinical experience has not really changed their approach, but for some it has increased their flexibility and client centred-ness, and has reinforced and clarified the ideas of others.

At the end of their studies, in the 3rd year interviews, the majority of students appeared to be using a client-centred, independent living model of practice:

I think, if they didn't want to get dressed then I wouldn't .. I'd find out why they didn't want to get dressed, and if they said I don't want to get dressed because it tires me out, well fine, what would you like to do instead, I don't think that getting dressed is the be all and end all of life, if they are happy in pyjamas, maybe you can't go out in the street in pyjamas .. it's better to use energies elsewhere in things that you enjoy doing than to struggle to get dressed.

MCT: so how are you going to get over this problem of her going out in the street in pyjamas?

mm .. help .. get someone in to help her get dressed, if that is what she wants .. she might not want it, .. she might want to go out in the street in her pyjamas - if she gets arrested that's life, it's not my problem [3:5];

and even highlighting the contrast between their personal approach to OT and what they had seen in practice:

firstly I'd find out what they meant by they don't want to ... bearing in mind that they may not want to do it there and then, or they may be wanting to conserve energy and so would say 'to me that's not important, I'd much rather .. go swimming twice a week but get someone else to get me dressed', so I'd find out where they stood .. on that ... because at the end of the day it's their choice .. just because getting up and dressed is a priority of mine doesn't mean that it a priority of hers ... and I think that's something that I've found quite hard, within a team before, is trying to justify to them that someone can get dressed, but they don't want to, they'd rather have someone in and then go somewhere else .. 'cos there's too much of a focus on the independent, ADL type tasks .. then they're knackering themselves for the rest of the day and spend the rest of their time sitting in a chair 'cos they don't have the energy to get out or have any other form of contact ... I think there's a problem with OTs sometimes, they get wrapped up in it and I think because it's a very .. functional, very visible thing for other team members to actually understand ... and the OT is seen as the person who looks at those things, they don't have to think beyond that .. provided someone can dress themselves then there's no problem ... that comes across in the whole team, in most of my placements .. [3:1].

However two students were still focusing on functional independence, normality and a rehabilitation model of practice:

.. I think it's best to leave it and then come back .... you could suggest that the patient isn't going to go home unless it's done .. the doctor wants to know if the patient can do this before they're let home, otherwise they're not going home, then that, hopefully, would change their mind, most people don't want to be in hospital, so .. actually saying 'look, unless you do this you're not actually going home', it's kinda harsh, but fair ... I think I'd either leave it and come back another time, or perhaps move on and do a couple of other patients before I'd come back and maybe they'd be in a better mood, whatever, they may have thought about it, realised they have to do it or need to do it, but I don't think I'd say 'leave it', or 'get someone else to help you' [3:6];

... but it depends on .. what her priorities .. what she's got at home, has she got kids and family to go back to, or has she got work to go back to ... and how much that means to her, .. and look at what she's already got, .. the RA's affecting performance in all these areas, isn't it better to try and sort it out and get back to .. possibly a similar level, but more realistically a .. lower level, but within the same area, maybe less hours

MCT: if she was saying 'my priority is to be able to work', what are you going to do?

well, she can't get into work without any clothes on .. I think .. she's got no concept .. work is going to bring in a lot of other things, she's got to get to work which she'll need to get up for and get dressed .. its ..... its probably necessary ... she's being pretty unrealistic if she's giving you

these priorities that she wants, and then turning round and saying 'I don't want to get up' .. [3:4].

Although even here there is an element of patient choice and a client-centred approach.

The students' ideas about how best to respond to a patient whose priorities are different from their own do appear to have developed over the 3 years of their training. Some students, and it tended to be the more mature students, were able, right from the beginning, to deal with the differing perspectives and to focus on the patient's needs. The majority of students began by focusing on functional independence and were unable to deal with a conflict of priorities except by imposing their own priorities. A small minority of the group, both in the 'younger' student category, appeared to be unable to move beyond the rehabilitation model, functional independence approach. They had a task and they needed to complete it, irrespective of whether the patient saw the task as appropriate.

Thus the majority of these students appear to be able to put the client-centred values of OT into practice, but are not always able to articulate them clearly in the abstract, which is in contrast to DePoy and Merrill's (1988) findings. Their students could articulate the values of OT but had more difficulty putting them into practice.

The fact that the majority of the students became more client-centred as they neared the end of their studies implies that their practice was becoming more empowering. This might be seen to be in conflict with the move back to more personal tragedy views of disability discussed earlier. Alternatively, focussing on the client's issues might involve focussing upon the problems and issues of impairment. Therefore, empowering practice is highly complex, as the therapist needs to be aware of the client's perspective but also needs to balance the various models of disability and to choose the appropriate one to underpin her interventions. These themes will be teased out further in the concluding chapter.

The scenario as it was discussed in the interviews might be seen as somewhat idealistic and divorced from the real world of practice. A discussion which evolved from the scenario was the issue of whose priorities actually drove the intervention process, the patient's, the therapist's or the system's.

Priorities and choices

Not all of the 1st year students felt that the patient's priorities were the most important. Four students felt very clearly that the patient's priorities came first and one student felt that the treatment process and procedure took priority. The remaining four students put a high value on the patient's priorities but tempered by the fact that the therapist might know best:

.... more often than not, the patient's, but they are not always going to know what is easiest or best, or safest, we've got training, but what they want is very important [1:9];

a bit of both, I think, you shouldn't force anyone to do anything, it shouldn't be just the OT's decision, you should discuss it and see what activities they might prefer, but then again, they've got to be therapeutic to that person, you've got to guide them, perhaps give them a choice out of a few, instead of just right you're going to do this now or you're going to do that [1:7];

The idea of compromise is present with this response and this was also apparent in the responses of the students who definitely put the patient first:

....I'd like to think I would (bend the rules) and go for the patient rather than the rules.. I can be very stubborn, but I can understand both sides, it's very hard if you haven't got the resources, but I think that's when you think, well maybe I'll have to compromise ... I don't think I can honestly say I would totally go for the patient ... but I would certainly try and compromise as best I could [1:1].

This respondent was the only one to mention resources as the main reason why the patient's priorities could not be addressed.

Of the 2nd year students only 2 saw the importance of priorities as balanced:

..... that depends on the situation, I think, generally they are all equally important, the OT and the consultant, they're just as important as the patient's [2:9].

The remaining students all saw the patient's priorities as the main priorities although how students dealt with conflicts between the patient's and the therapist's/ hospital's priorities differed. Students divided into 'idealists' and 'pragmatists'. The idealists focused totally on the patient's priorities and would take on the consultant etc. on the patient's behalf:

> *I would always try and come down on the side of the patient, in a ward meeting I would put forward the reasons why that person should stay, so that at least if you try and fight for that, then you've done your bit, so you should always speak up if you don't think its right [2:8].*

The pragmatists, on the other hand, attempted to work for the patient but within the constraints of the system and accepted that compromise might be necessary:

> *'cos quite often the system is discharge as quick as you can, and you haven't got the time ... if it's possible to delay them being discharged, then I do, and I have done, in London I did that ... if not you try and do as much as you can within the time, and then discharge and make sure that either you follow up or you refer them to another service, so you can do it, and your goals and their goals are still achieved [2:5].*

By the 3rd year interviews the students' ideas had become much more complex and sophisticated. One of the pragmatists had become more of an idealist and one of the idealists had moved closer to a pragmatic approach. A common thread was that whilst the patient's priorities should drive the

interventions, lack of resources may influence what is possible, and that it is important to be honest about this potential conflict:

> *if limitations don't get in the way, its OK to say that but you might not have the money, .. but I think the important thing is to .. if you haven't got funds to do things, you should say to the patient 'this is the ideal situation, but unfortunately we haven't got the funds' .. then go back and re-evaluate and sit down with them and go through the options, don't ignore them, and don't make the decision without them [3:5].*

One student put the priorities into the context of the model of practice she might be working within:

> *... the client, principally, I would say, and then you work round that ... you may come in with your own ideas but it needs to be what they want, otherwise its a waste of time, I think.*
>
> *MCT: does that always work in practice?*
>
> *no*
>
> *MCT: why not?*
>
> *because a lot of physical departments would be working within a biomechanical model or .... and certainly from a medical viewpoint. I suppose the idea is that you would look at .. curative .. measures to begin with, and give it a diagnosis and find a way of curing, and if that doesn't work then you'll veer more towards ... a social ... it's a lot to do with the setting, 'cos I think much more in the community, you would be able to look at other factors and not be restricted [3:8].*

Thus, by the end of their training all of these students were talking in terms of a client-centred model of practice. The majority of respondents were able to articulate the potential problems that might exist within this framework in terms of resources and conflicts between what the therapist thinks is appropriate, based on her training and knowledge, and what the patient thinks is appropriate, based on her/his experience of her/his problems. The level of sophistication of the arguments also varied, with only one student able to locate her discussion within the context of how intervention priorities might vary depending on which model of practice one was actually working within.

Successful treatment

Addressing and dealing with the patient's needs and priorities might be seen as a successful outcome of treatment. Abberley (1995) explored success and failure in OT and proposed that successful OT was defined by client satisfaction and specific performance criteria, whilst failure was defined in terms of lack of resources, problems with 'the system' or factors to do with the patient. All of these things, Abberley argues, serve to reinforce the individualistic nature of disability and to reinforce OT's oppressive ideology. This research was published just as I was preparing for the final round of interviews; it seemed pertinent, therefore, to explore with the 3rd year students their ideas about successful and unsuccessful treatment.

The responses of the 3rd year students to the discussion of 'successful' treatment are quite telling in terms of what Abberley sees as OT's individualistic and oppressive ideology. If oppression is viewed in terms of focusing on the individual, then all of the respondents base their practice as OTs on an oppressive ideology. Success, for all of the respondents, was seen in terms of achieving goals and the client being able to do things. However, if the notion of client-centred practice is drawn in to the equation, then the ideology appears much less oppressive. It should, however, be noted that some of the respondents were more client-centred than others.

The less client-centred respondents saw success as:

> *.... you've achieved the goals you set out to do .... there's a marked improvement in the patient's .... ability ... and they're much happier, and perhaps more confident in actually doing things which they couldn't do before .... perhaps they've not got back to the state which they were previously in, but you know that that's the best they're going to get .. [3:6].*

The idea that the client was 'happier' was often mentioned. This was linked with the idea that part of successful treatment was a good therapeutic relationship:

> *.... maybe, not even achieving something, but just the fact that you've sat down and built up some sort of rapport with someone .... even getting to know the person [3:7];*

and also the importance of the client's motivation and the effect that might have on treatment:

> *the client has to have the insight and has to have the ... want to deal with it [3:3].*

The more client centred respondents saw success wholly in terms of meeting the client's needs:

> *the person being satisfied with what has happened ... it might not be a big thing that you have done, but if it empowers them, then they can carry on with what they want to do, and it's met their expectation and their aims .. then that's far more important to me, than if I'd wanted them to get dressed and they still couldn't get dressed but they could do other things .. then they don't have to get dressed [3:1].*

One respondent commented on the way her thinking had changed from seeing functional independence as successful treatment to a broader approach:

> *I think in the first year, when you're out practising, and you think of the things OTs do, and it is to strive to make somebody dress themselves, or strive to get somebody to make a cup of tea in the kitchen, or whatever, but now I think, it's nice for them to be able to do that, but only if they want to ... because treatment is not about making them do things they don't want to do [3:7].*

Unsuccessful treatment was seen in terms of not achieving the goals that had been set. Various reasons were given for not achieving goals. These included: lack of resources; lack of insight or motivation on the client's part:

> *.. no matter what was said to him, he wasn't going to do it, and even though he wasn't happy with what had happened when he left, because he still wanted to drive his car, but it wasn't anything that I had done that had stopped him driving his car, it was because he didn't ..want to really, he wanted it just to be given to him, he didn't want to work towards it .. so I was successful in that I noticed that he wasn't going to do it .. and I was successful in wanting to stop, instead of wasting even more time and getting more and more disgruntled , but the outcome wasn't successful [3:5];*

or lack of clear negotiation between the therapist and the client:

> *If you ignored the person's wishes, I think, ... and setting goals too high so that they're not achieved, I think that's probably the worst thing you can do ... [3:7];*
>
> *... I've seen OTs make promises that have fallen through, and I see that as a form of failure ... the actual OT is the failure, if they can't do it then they should say ... it has a poor effect on the patient, because things don't happen [3:1].*

The client and the therapist might have different perceptions of success:

> *.. it might be that you think it's been successful, but they don't for some reason, then that's because you haven't been looking at their criteria as well [3:8].*

One student was pragmatic and acknowledged that as a therapist she probably might not be able to do everything

> *but I think you have to accept that there are going to be failures, that you can't meet every expectation, because we are living in a world like that, and you can fight the system until you are blue in the face but some things won't change the resources might not be there, but enabling the person as much as possible, and even if that's only a little bit, I don't see that as a bad outcome .. you can have one that is less than what you wanted .. [3:1].*

It is interesting to note that, in contrast to Abberley's (1995) findings, these students did acknowledge that they, as therapists, might contribute to unsuccessful treatments.

The idea of the therapist's responsibility was also clear when the students were discussing finishing treatment. The majority of the students saw the decision to end treatment as the joint responsibility of the client and the therapist. It was felt that the client should make an informed choice:

> *as long as it was an informed choice, if they thought it was over but there was stuff that we could still do but they didn't know about it .. then that's the fault of the therapist, but as long as it's an informed choice .. [3:1];*

Although for some students the therapist was more in control:

> *.. if you've done an initial interview or talked to the family, and you've established how ... good they were at certain things before they came*

in, you can see .. what stage they were at before they've come in so you'd be able to picture ... and you'd be able to see how much of their maximum they've achieved, sometimes a patient might be quite lazy or .. apathetic, and it could be a number of reasons why they think they've achieved, maybe they don't want to do any more, they might be bored of what you are doing, you might need to change it .... perhaps they want to do something else, I think you've got to make OT interesting for the patient, not just do what you want to do with them, but involve the patient and get then to do activities that interest them [3:6].

A number of students acknowledged that 'ideally' the therapist and client decided, but often resources were the deciding factor about when treatment ended:

.... doctors,... doctors often put a spanner in the works and say 'you've done enough, she's, or he's, good enough to go home' ... [3:6];

in an ideal world it would be nice for them to say .. or you both to say you've achieved something, but when you're out there working, and you've got limited time and resources and things, then really I think its down to you as the OT, but that is down to circumstances and not because it's what you would wish to do [3:7].

The practice of OT would appear, therefore, to be a balancing act where the client's priorities and needs are seen as of primary importance but must be weighed against the pragmatic needs of lack of time and resources.

Changes and influences

During the 3 years of their OT studies these students have studied a variety of 'academic' modules and have experienced a range of fieldwork placements, where they have come into contact with disabled people as clients and patients. During the academic modules the students will have learnt about disability and the experiences of disabled people and may also have met and been taught by disabled people. They have also observed OTs in practice and have been able to see how they respond to disabled people as clients. As a way of drawing together the interviews, each respondent was asked to reflect on the key influences of the previous 3 years. They were also asked about their perceptions of OTs' attitudes towards disabled people.

The teaching team for one of the academic modules (1528: Practice in Partnership) is made up of both disabled and non-disabled people. This module often has a powerful effect on students. The findings from the questionnaires and interviews with students who have taken this module will also be discussed in this section.

The responses of the interview cohort to what had influenced them, or caused changes, in their thinking about disability issues were very varied and extremely difficult to draw together. This may say as much about the researcher's interviewing skills and non-directive style as it does about the respondents' views.

Not surprisingly Fieldwork placements were identified by the majority of respondents as a key influence in the ways their thinking about disability had changed or refined. Placement gave them the opportunity to meet people, to challenge their thinking or their pre-judgements:

> *..... I think, my second year placement ... because it was the one, it was physical, and at the time I knew I wanted to do psych ... I was a bit more wary about going into it, it was areas that I didn't want to touch, and I didn't want to work in, and it taught me how important it is not to prejudge, and I think you can then generalise that to many other settings, and also with people, you can think I really don't want to work there, and I think it shocked me so much that I could work in that setting and really enjoy it ... [3:1].*

Only 3 of the respondent group had taken 1528, but all of them commented on the effects of the module on their thinking and ideas. For two of them the effects had been positive. It had given them ideas for their dissertations and had helped them to refine and articulate their ideas about their role with disabled people:

> *I think I was interested in why the handful, 'cos disabled activists are so few and far between, I was trying to work out what had made those who had become activists, and I think it was because of the disabled lecturing staff, who were quite pro-active themselves, thinking what spurred them to go and do it, ... also the way the module was done, was, like, this is the way everyone is going to be feeling, thinking, but it isn't, it's only such a small handful ... I suppose I was thinking about the*

future, and how I could help people who don't have that outlook .. to maybe become politicised so that they could fight for their own rights ... but there's a danger that if every disabled person becomes activist, we're not going to have a job, because they are going to say 'we don't need you any more', but it's a fine line, but I think we can work as advocates quite nicely, to enable people to get what they want .. but no matter how much .. it's never going to be what every disabled person wants .. because .. if you've just had a stroke you're not going to want to fight for your rights, you're just going to want to get back to how you were before, I think it's important for those who want .. who feel disgruntled or who are having problems, or feel they are being discriminated against .. it's our role to help them to come to terms with it and find out what they can do about it, and for those who don't .. not to force them .. because individual wishes [3:5].

However, for the third respondent, the effect had been more negative. The disabled team members had been viewed as extreme and they had reinforced stereotypes (as Donaldson, 1980, would predict) and had not encouraged the respondent to look at the broader issues of disability:

these politically active people are just a bit extreme ... I think they're unrealistic, to be honest .. they get at other people a lot for not saying the right things or doing the right things, and I just think that the general population, they haven't come across it before and they are just trying to help and doing what they think is best, so you shouldn't knock that, ... on Practice in Partnership we had a handout on what you can do

and what you can't do for disabled people, and one of them was not hold the door open, and I think that's just ridiculous, 'cos I'd hold the door open for anybody whether they were in a wheelchair, crutches or whatever .... in many ways I went against what she said, 'cos I always have done, and it's always worked ... [3:7].

Attitudes of OTs towards disabled people

All of the respondents would say that they had positive attitudes towards disabled people, in terms of seeing the person rather than the disability. However, they were less convinced that OTs in general held positive attitudes towards disabled people. A key theme of these discussions was that OT was a job and that part of being a 'professional' was to focus on the person rather than the disability. It appeared that students were aware that there might be professional attitudes which were positive, but that personal attitudes might be less positive:

I think it's easier to relate and be very positive in a work situation, but in a non-professional, more personal level it's still difficult ... perhaps we're still .. our attitude's still not as positive as it should be, because we don't know the person, but as soon as we get to know the person it changes .. I still think that OTs .. who come across people with disabilities in the street, I still think they .. they feel the same way as people who don't know as much, it's always difficult because .. you think you know more about disability .. it's still difficult relating to them and .. if it's not in a work ..[3:6].

However, as we saw in the previous chapter, OT students, unlike physiotherapy students, did not hold significantly different professional and personal attitudes. Perhaps these qualitative reflections indicate that differences between personal and professional attitudes do exist.

Reflections on Practice in Partnership

As we saw above, the module 1528: Practice in Partnership (Disability), which focuses on disability issues, evoked a mixed, but always powerful, response from the students who studied the module. The responses from the 'Practice in Partnership' interviews and questionnaires were equally mixed and tended to reflect the comments made by the cohort interviewees. All of the respondents felt that the module had challenged them. It had challenged them both personally and professionally. As professionals they had become aware of, and committed to, the notion of partnership as a philosophy of practice. At a more personal level, many of the respondents had been surprised to discover that they had stereotypes and prejudices about disabled people. They were surprised that disabled people should want to be seen as different rather than the same as able-bodied people. Less positively, some students felt that assumptions were made about the attitudes they held and that they were being told what to think, which had a counter-productive effect.

The idea of 'celebrating' disability was particularly challenging and one which few students felt able to accept. Again, the presence of disability activists who were so counter to the stereotypical image of disability served to

reinforce existing ideas. As one interviewee reflected, sadly, the module was a good idea which did not really work in practice.

Summary

In terms of the research questions identified at the beginning of the chapter, how well have the qualitative data answered these questions? The qualitative findings aimed to explore whether, despite the findings of the personal/ professional questionnaire, a 'professional' attitude towards disabled people exists, the nature of the 'professional' attitude, and whether the attitudes expressed by the student cohort were empowering or oppressive.

It has become clear that whilst the students firmly believe that they see the person before the disability, this is not always the case. Equally there do appear to be differences between personal and professional attitudes. The respondents do seem to respond differently to friends, colleagues and clients with disabilities. The students did acknowledge that they might have professional attitudes which might differ from their personal attitudes. The personal attitudes see the person first; the professional attitudes tend to see the problem first, thus reinforcing the personal tragedy view of disability, and placing OT firmly within the oppression camp.

Whilst the respondents, for the most part, talked about their professional interactions with disabled people in terms of the principles of client-centred practice, empowerment and choice, their focus on the individual and her/his

'problems' might be seen as oppressive. However, as mentioned earlier, the use of specific models which help to focus the interventions upon what the client perceives as the issue, or problem, might be perceived as an empowering intervention for that individual. It has been noted that the students were not always able to clearly articulate the theoretical underpinnings of their interventions or of their ideas. Thus it might be that, whilst the students articulated reasoning appears to be oppressive, this is due more to an inability to articulate theory and models of intervention rather than being based on a truly oppressive philosophy of OT.

Chapter 8

EMPOWERMENT OR OPPRESSION:

A DISCUSSION OF THE ISSUES

This chapter will begin by summarising the findings of this research, in order that the various threads of the study can be drawn together to give an overview of the research and to highlight the key issues to be reviewed and discussed. The limitations of the research will then be discussed and the implications of these limitations for the interpretation of the findings will be explored. The findings will then be discussed in the context of the previous research, the key issue of the oppression-empowerment duality will then be analysed in the light of the findings with an emphasis on the notions of impairment and the individual. The value of the oppression-empowerment duality will be questioned and an alternative conceptualisation will be proposed. The implications of the research and the theoretical model will then be discussed in terms of their value for the professional education of OTs and the sociology of disability, and also the implications for future research. The chapter will conclude with critical reflections upon the research process.

Overview of the findings

The aim of the research was to investigate the concepts of, and attitudes towards, people with physical disabilities held by OT students, so that a theory of professional attitudes and professional action could be developed. Quantitative and qualitative data were collected to establish the nature of 'professional' attitudes. The research aimed to address the following research questions:

what, amongst OT students, is a 'professional' attitude towards disabled people?

Are the attitudes of OT students towards disabled people any different from those of other students?

Do these attitudes change over time?

Are there any differences in the 'personal' and 'professional' attitudes of OT students towards disabled people?

How accepting of disabled people are OT students, would they be willing to work with disabled people as colleagues?

Is there a hierarchy of relationships for people with different impairments?

What does the 'professional' attitude mean in practice?

How does this 'professional' attitude develop?

What factors influence its development?

Does contact with disabled people have any effect on attitudes?

Do OT students express attitudes and values which oppress or empower their disabled clients?

Drawing from the quantitative findings, the essence of a professional attitude would appear to be:

- a highly positive attitude towards disabled people, as measured by the ATDP;
- no different from personal attitudes towards disabled people, as shown by the personal/professional ATDP scores;

- a perceived willingness to associate with disabled people in a variety of settings, as measured by the social distance scale;
- a perceived willingness to engage in a range of close social relationships with some physically disabled or impaired individuals, as shown by the Disability Social Distance Scale; however individuals with a history of mental health problems, 'disfiguring conditions' or 'undesirable personalities' are seen as less socially acceptable;
- a willingness to acknowledge that some physically disabled individuals might be suitable to train as OTs, as measured by the Suitability for OT scale; however people with mental health problems and more severe physical disabilities (e.g. blindness, deafness, wheelchair user) might be less suitable or acceptable to train as OTs;
- a broad view that disabled people are:

  trustworthy;

  an asset to society;

  in good health;

  mature;

  communicative;

  physically attractive;

  have difficulty finding a job;

  as indicated by the semantic differential;
- a tendency to focus on the positive aspects of the individual, as shown by the factor analysis of the semantic differential findings.

These findings can be expanded by drawing in the qualitative findings, where a professional attitude would appear to include:

- using the client's priorities and needs to govern interventions;
- an emphasis on client-centred practice;
- choice;
- a tendency to focus on the individual and her/his problems and needs, rather than societal issues;
- an emphasis on the personal tragedy view of disability;
- a contrast with personal attitudes, which would see the person first and the disability second.

Factors which appear to influence professional attitudes are:

- contact with disabled people, especially working with a colleague who is disabled, however meeting a disability activist might have less positive effects;
- stage of professional education; amongst the OT students the 2nd year students tended to hold the most positive attitudes on all of the measures used in the study;
- gender might have some effect on attitudes;
- age does not appear to be a confounding variable.

Limitations of the study

Before discussing these findings in the context of the previous research or drawing any conclusions based on the findings, it is necessary to discuss the limitations of the study. The findings can then be viewed not only in the context of previous work but, also in the context of the reliability, validity and trustworthiness of the study. As the design of the study adopted an integrated approach, it seems appropriate to review the research in terms of reliability,

validity *and* trustworthiness, and to use the appropriate perspectives for the two aspects (qualitative and quantitative) of the study. The limitations of the quantitative parts of the study will be discussed first, and then the trustworthiness of the qualitative parts of the study will be assessed. The limitations of the study as a whole will then be discussed.

The rigour of the quantitative aspects of the study

Two areas must be highlighted when discussing the limitations and rigour of the quantitative aspects of this study. Firstly the limitations of the sample must be explored and, secondly, the factors within the research tools that might limit the rigour and generalisability of the findings.

The sample for the main part for the study has two flaws. One of these flaws relates to the OT respondents and the other to the non-OT respondent group. The original idea for the OT part of the main study was to follow a cohort of students though their degree studies. This would have given a true longitudinal design, where the questionnaire responses of each student could be compared across the three years of the course. However only a third of the potential respondents completed all 3 questionnaires. This meant that the study had to be seen as a quasi-longitudinal design and that each OT questionnaire was treated as being from a separate respondent.

The problem with the non-OT sample is, potentially, more damaging to the integrity of the study and its findings. As explained in the Methodology chapter, gaining access to non-OT students was not as simple as gaining

access to OT students. This meant that the researcher had to rely on the good will of colleagues to distribute, follow-up, and collect questionnaires. The inevitable consequence of this was that far fewer non-OT respondents returned completed questionnaires. This meant that there was an imbalance in the size of the various respondent groups, which meant that less rigorous non-parametric tests had to be used to analyse the data. However, a greater problem with the non-OT sample was the fact that proportionally more male students completed the questionnaire. This created a gender imbalance between the groups. This might not have been problematic. Yuker and Block (1986) report equivocal results on the effect of gender on attitudes towards disabled people, whilst both Furnham and Pendred (1983) and Lyons (1990) found no gender effects. However, when the data from this study were analysed to review the effect of gender on attitudes towards disabled people, there was clear evidence that amongst non-OT students gender was a significant factor. This finding casts doubt on the rigour of the comparisons between OT and non-OT students. It would, therefore, seem sensible to ignore the non-OT data and thus concentrate upon the findings relating to OT students' attitudes towards disabled people. The author felt, however, that it was important to include the non-OT data within the quantitative results chapter.

Within the Disability Social Distance part of the study, again an imbalance of respondent numbers renders the analysis less rigorous. Conclusions drawn relating to the 3rd year group must be viewed with caution because of the smaller respondent numbers in this group.

As the study progressed a number of issues became apparent with the research tools. However, as the main questionnaire was being used three times within the longitudinal study and results would be compared across year groups, it did not seem appropriate to change measures. The fact that the ATDP has limitations and critics should be noted here. However, this will be discussed in detail later in this chapter, when the factor analysis of the ATDP results for this study will be considered in the context of other factor analyses of ATDP data.

The use of mid-point categories (e.g. maybe, don't know, probably) is always hotly debated. Yuker et al (1960) avoided a mid-point on the ATDP. Avoiding a mid-point forces respondents to make a choice. However, the use of a mid-point response might imply not only a cautious response but also a more realistic response. This might be the case in both the Social Distance Scale and the Suitability for OT Scale in the main questionnaire for this study. In the Social Distance Scale respondents were given three response options:

definitely

may be

never.

Responding that they would 'definitely' 'go out with a disabled person' might be interpreted as the most positive response. However, 'may be' might be a more realistic and truthful response, given all of the other factors that might be involved in choosing a potential partner. Whilst highlighting some interesting variations between the different respondent groups, the data from

this Scale, probably, have limited value in the overall understanding and exploration of attitudes within this study.

Whilst the Suitability for OT Scale had four response options:

unsuitable

probably unsuitable

probably suitable

suitable,

the two 'probably' options can be seen as mid-point options. Using these response options again highlights the complexity of choice. This time the choice of whether any individual, disabled or non-disabled is suitable to train as an OT. 'Suitable' might be the most positive response, however, 'probably suitable' is, possibly, the more realistic response.

Both of these Scales highlight the complexities of identifying, and measuring, true as opposed to politically correct attitudes towards disabled people.

The final research tool to be discussed in terms of its limitations is the Semantic Differential Scale. This was the most contentious part of the main questionnaire. The aim of the Semantic Differential Scale was to create an overview (or stereotype) of the perceptions respondents' held about disabled people. However a number of respondents expressed discomfort at producing an image of a 'typical disabled person' as no such person exists. A number of respondents failed to complete this section, whilst other respondents either created a mid-point:

_:_:_x_:_:_

or alternated between the two mid-points:

_:_:_:x:_:_

_:_:x:_:_:_

_:_:_:x:_:_

_:_:x:_:_:_

thus invalidating their data. This meant that a number of respondents were recorded as having missing data for this section of the questionnaire. The number of respondents who had missing data for this section is 27, which is 9.5% of the total number of respondents. Interestingly the missing data are spread evenly between all of the respondent groups. Caution should, therefore, be exercised before taking the findings of the Semantic Differential Scale at face value.

An issue highlighted by all of the quantitative tools, which is discussed in detail later, is the oppression-empowerment dichotomy. The premise, upon which most attitude scales are based, is that there is a positive attitude at one end of the scale and a negative attitude at the other end of the scale. For this study the positive-negative dichotomy was also seen to represent the empowering-oppressive dichotomy. However, as will be discussed later, this is something of a false dichotomy. Oppression and empowerment are not necessarily opposing poles of a single continuum. This highlights the need for the integrated methodology in this study. The quantitative tools have raised interesting issues and given a broad overview of the topic. However, it

is the qualitative aspects of the study that can provide the finer detail of the issues of empowerment and oppression in OT practice.

The trustworthiness of the qualitative aspects of the study

The size of the respondent group for the qualitative aspect of this study must be looked at critically to assess the trustworthiness of this research. The processes used to ensure trustworthiness throughout the qualitative part of the research will also be reviewed to outline the rigour of the research.

The original number of respondents chosen to form the interview cohort of this study was 10 students. This represented 10% of the year group. The group was drawn from a stratified profile of the year group so that the age divisions within the year were reflected in the respondent group. Due to the natural wastage that occurs in any course the respondent group was reduced to 8 by the 2nd year of the course. The average wastage from any OT course is between 5 and 10%. Thus every effort was made to ensure that the respondent group was qualitatively representative of the cohort as a whole. One variable that was not included was gender. About 5% of the students in any OT year group will be male. However it was decided that, to avoid tokenism, no male students should be included in the interview cohort. The number of disabled OT students is, sadly, negligible, and so it was not deemed appropriate to attempt to include a disabled student in the interview cohort. The small size of the group and the lack of male or disabled respondents might be seen to weaken the rigour and trustworthiness of the data. However, size is not everything in qualitative research and the author

considers that the interview sample did provide a representative picture of the year group concerned, given the spread of age and experience within the group. Qualitative research texts do not provide a magic number for the ideal sample size. The goal of qualitative research is to provide deep, rich data. The author felt that, within the constraints of the study, a group representing 10% of the year group would provide the necessary deep and rich data and provide a credible view of the attitudes of OT students towards disabled people.

Krefting (1991) identifies four aspects of trustworthiness and rigour in qualitative research:

credibility

transferability

dependability

confirmability.

The qualitative aspect of this study will now be reviewed in the light of these four aspects. Credibility is about getting the true picture of the phenomenon being studied. The strategies used to achieve this include;

prolonged and varied field experience

member checking

reflexivity.

The interviews were carried out over 3 years, which could be seen to be prolonged field experience. However, data collection was limited to interviews, which do not provide a varied field experience. Other data collection methods could include diaries or observation of students on

Fieldwork, but these were not seen as appropriate or practical within this study due to time and work constraints on both the researcher and the respondents. Member checking involves getting respondents to check both the transcripts of their interviews and the analysis of the data. This was done in this study, although no comments were received from the respondents. The author attempted to be reflexive by keeping a field diary and by being aware of and recording her assumptions and ideas as the research progressed.

Transferability refers to whether people outside the research setting can identify with the setting, which is done by sampling which replicates the key variables of the population as a whole. As discussed above, this was attempted within this study.

Dependability refers to whether the study and the findings could be replicated. The main tool here is audit. It is hoped that the process of this study, the reasoning behind it and the analysis have been explained sufficiently clearly to allow the reader to audit the research.

The final aspect of trustworthiness is confirmability, which is related to the lack of bias within the study. The main strategy for confirmability is external audit. As explained in the previous chapter, the interview data for this study has been subjected to external audit and the findings have been confirmed. The findings have also been presented at conferences, where other OTs have acknowledged the trustworthiness of the findings.

Limitations of the study as a whole

Overall a limitation of the research is that it must be viewed within its temporal context. This research was started in 1990. The cohort of OT students who formed the main group of respondents for the study began their OT degrees in September 1992. The cohort of students was only the 2nd cohort to begin a degree programme in Occupational Therapy at Oxford Brookes University. OT education was in transition, from a skills-based, technical-rational training to an academic, theory-based, post-technocratic education. OT was moving from a medical model of illness to a biopsychosocial model of health, but had yet to completely integrate a social model of disability (or health) into its thinking. Disability theory was developing, but tended to be dominated by a predominantly Marxist view of oppression. Feminist theory had only peripherally impinged upon the field. The sociology of the body was in its infancy. Thus both the study and the professional socialisation of the students it studied took place in a time of developing theory and professional ideas.

The research tools used in the study are also a reflection of the temporal context of the study. The ATDP is flawed. However, it was the tool of choice for other studies of OT students and thus allowed comparisons to be made with existing research. Other tools have subsequently been developed (e.g. Gething & Wheeler, 1992) which might provide a sounder basis for study in the future. However, in the early 1990s, when this study was designed, the ATDP was the measure of choice within the field of measurement of attitudes towards disabled people. The other measures used in this study were

adaptations of non-standardised tools used by other researchers. These were used with the aim of expanding the exploration and understanding of attitudes towards disabled people.

The trustworthiness of the study as a whole will now be addressed. Whilst the qualitative aspect of the study might have lacked credibility because of the lack of varied field experience, the use of both qualitative and quantitative research methods, within in an integrated design, to triangulate the findings can only enhance the credibility of the study.

The transferability of the study is mixed. As discussed above, the non-OT data are flawed and so must be ignored. This data are, therefore, not transferable, they does not represent the demographic variables of a non-OT student population. The OT data, however, do demonstrate transferability, within its temporal context. The study was a case study of one OT course and as such is representative of that course. The context of the study has been described and it is up to the reader to identify aspects of the population and the study which can be replicated in her/his own setting.

The issue of dependability is interesting. Because the study is bound by its temporal context, the question 'if you asked the questions again will you get the same answer' is impossible to answer. The same questions can never be asked again. However, if the same questions were asked of the data, then the process has been described and the same answers should arise.

The confirmability of the study has, to a greater extent, been discussed above. The data have been subjected to external audit and the reasoning and the assumptions that underpin the study have been explained.

The study, as a whole, has highlighted the complexity of measuring attitudes towards disabled people and the complexity of the attitudes themselves. The goal of the research was to explore the attitudes of OT students towards disabled people and how those attitudes might ebb influenced by the professional socialisation process of becoming an OT. Thus, links between attitudes and practice were being addressed. Recent discussions amongst disability researchers on the Internet (*disability-research@mailbase.ac.uk*) have proposed that attitudes cannot be changed. Perhaps, if this study were to be repeated, the focus should be on the expression of attitudes in terms of professional OT practice (i.e. the qualitative aspects of the study) rather than on the measurement of attitudes per se (i.e. the quantitative part of the study.

Putting the findings into context

The limitations of the study have been discussed, and must not be ignored when reviewing the findings of the study. However, the results must also be considered in the light of previous research. This section will attempt to view the findings of this study in the context of previous research.

Attitudes

That OT students hold highly positive attitudes towards disabled people should not be surprising in the light of the previous research (summarised in

Chapter 4). Whilst there was equivocal evidence for significant differences between health professionals' and lay attitudes (e.g. Huitt & Elston, 1991, Elston & Snow, 1986, Duckworth, 1988, Bohlander, 1985) and OT and non-OT attitudes using the ATDP and other measures (e.g. Lyons, 1990, Estes et al, 1991), the attitude scores for OT students are consistently higher than the norms given by Yuker and Block (1986) (e.g. Lee et al, 1994, Kirchman, 1987, Estes et al, 1991). The norm for the ATDP-A given by Yuker and Block (1986) is 117.1; the mean score for OT students in the main part of the study was 137.18 and in the personal/professional part of the study the mean scores were 137.05 (personal attitudes) and 136.25 (professional attitudes). When Speakman and Kung (1982) attempted to establish a norm ATDP-A score for physical therapists, and thereby establish the ATDP as a screening tool for applicants to physical therapy training, their median score was 124.5. Vargo and Semple (1988) and Speakman (1989) argued that professional attitudes may well be different from personal attitudes. Speakman (1989), in fact, arguing from the premise that professional attitudes may be more negative as they could be based on seeing the patient as 'different'. Vargo and Semple (1988) found that physical therapy students held significantly more positive professional attitudes in comparison to their personal attitudes, with a mean ATDP-A 'professional' score of 114.3. Interestingly this positive score is well below the mean OT student score in this study, the physical therapy median score in Speakman and Kung's (1982) study and Yuker and Block's (1986) norm score. Thus, in terms of the ATDP and in the light of the previous research, OT students, both personally and professionally, hold very

positive attitudes towards disabled people, in other words, they see disabled people as no different from themselves.

These highly positive scores could lend support to Benham's (1988) call for screening of attitudes prior to admission to OT education and Speakman and Kung's (1982) proposal for the ATDP to be used as a screening tool. However, the nature of a positive attitude, as measured by the ATDP, must be reviewed. Yuker et al (1970) based the ATDP on the explicit assumption that a positive attitude implies that disabled people are no different from non-disabled people. That disabled people have similar characteristics to non-disabled people and that disabled people should be treated in the same way as non-disabled people. This begs the question that being seen as no different from non-disabled people is, in fact, a positive attitude towards disabled people. Being seen as no different denies the disabled identity, much as ignoring culture, gender or sexuality denies aspects of those identities, and disability activists would question the validity of this view. Seeing disabled people as no different from non-disabled people denies the social implications of disability and reinforces the individualistic personal tragedy view of disability. It could, therefore, be argued that, by expressing highly positive attitudes which suggest that disabled people are no different from, and should not be treated differently from, non-disabled people, OT students are, in fact, expressing oppressive, personal tragedy views of disabled people.

However, any conclusions drawn from the ATDP data must be viewed with considerable caution. The factor analysis revealed that, rather than being an uni-dimensional measure, the ATDP is, in fact, multi-dimensional. Factor analysis revealed 9 factors. However, only 3 of the factors appeared to be meaningful. These factors represented 'emotional strength', 'sense of self-worth, and 'competitive equality'. Previous factor analysis of the ATDP had found 2 factors: hypersensitive-depressed and benevolent inferiority (Siller & Chipman, 1964); or, derogatory personality stereotypes and benevolent social stereotypes (Antonak, 1982); all of which appear to represent how disabled people differ from non-disabled people. Other studies have identified 4 factors: coping-succumbing, emotional need-emotional satisfaction, sensitivity-self-consciousness and inferred morality (Livneh, 1982); or, normality, emotionality, introvert and sensitivity (Furnham & Pendred, 1983). Whilst there may be some commonality with some of the factors, e.g. those concerned with the emotional life of disabled people, there appears to be little overlap between the various factors. That the ATDP is measuring more than the perception that disabled people are no different from non-disabled people is clear. What is also clear is the complexity and multi-dimensionality of attitudes towards disabled people. Disabled people can be seen as depressed, socially introverted and hypersensitive (Furnham & Pendred, 1983) or in terms of their emotional strength, sense of self-worth and need to be treated with equity, as in the current study. The complexity of attitudes towards disabled people is clear. The adequacy of the ATDP to measure this complexity adequately is very much in question.

A further aspect of the OT students' positive attitudes towards disabled people is their apparent willingness to associate with disabled people in a range of social settings and for the students to see disabled people as suitable to train as OTs. Where the ATDP might be seen as measuring the affective and cognitive aspects of attitudes, the various social distance scales are an attempt to capture and enumerate the behavioural components of attitudes towards disabled people.

Whilst no comparable studies exist for the social distance scale in the main questionnaire, it is possible to review the findings of the Disability Social Distance Scale and the suitability for OT data in the light of previous research, and this was done in Chapter 6. It is interesting to note the more negative response to people with mental health problems in comparison to those to people with physical disabilities. Given, the division of OT Fieldwork placements between physical medicine and mental health settings, the likelihood of any OT working in the area of mental health and the incidence of mental health problems in society, this finding is worthy of further investigation beyond the scope of this study.

The comparison of the Disability Social Distance Scale and the suitability for OT scales highlight clear divisions between personal and professional attitudes, with people with some impairments seen as suitable for OT training but less so for personal relationships (e.g. above knee amputee) and vice versa (e.g. asthmatic, blind, deaf). The relatively accepting attitudes of OT students for disabled people to train as OTs are also interesting in the light of

previous research. This research highlighted the experiences of health professionals who did not feel 'welcome' as professionals (Kerr, 1970, French, 1986, 1988, O'Hare & Thomas, 1991), although, Craik (1990) does imply that OT is different and actively encourages disabled people to enter the profession. This welcoming approach appears to be replicated in the findings of this study, where OT students do appear to be willing to consider people with a range of impairments as suitable to train as OTs. This may, however, say more about the students' perceptions that disabled people *ought* to be welcomed into OT, than any real commitment to anti-oppressive practice. It may, as Chinnery (1991) argues, be merely 'window dressing' and an illusion of acceptance. However, as, for the most part, the OT students were more positive in their responses than the OT faculty, it may indicate a greater openness and willingness to adopt less discriminatory and less oppressive ideologies. Whether this is borne out in the real world of practice remains to be seen. Based on anecdotal evidence of a recent OT graduate, who was profoundly deaf, the profession is not as non-discriminating as it should be. This is supported by Elliot et al's (1992) finding that only 4% of OTs in the United States were disabled. These findings highlight a further area for future research beyond the scope of this study.

The final aspect of OT students' positive attitudes towards disabled people to be drawn from the quantitative findings and reviewed in the light of previous research is the image of disability expressed by the students. The image of disabled people that can be drawn from the data is a highly positive view of disabled people as a valuable asset to society, although this is tempered by

an acknowledgement that disabled people may have difficulty finding employment.

The images of disabled people reviewed in Chapter 2 ranged from disabled people as a sub-human menace to society to brave and courageous individuals battling with adversity. Whatever the image, the central focus is the disability rather than the individual or the problems created by society. All of these images are essentially oppressive.

The images of disabled people, which emerge from this study's data, are closer to the brave and courageous individual image. The images that emerge tend to be over positive, and whilst any individual should be seen as 'an asset to society' the general flavour of the image is that the students are trying very hard to be 'politically correct' and not to express any negative stereotypes. This may say more about the students' response to the use of the semantic differential as a research tool than about their images of disabled people, which echo Freeman's (1988) conclusion that respondents may be 'squeamish' about using certain negative terms. As previously mentioned, 9.5% of respondents omitted the semantic differential part of the main questionnaire. They often wrote comments to the effect that it was impossible to complete, as everyone was different. A number of other respondents opted for a point between 3 and 4 on the response scale or alternated between 3 and 4 as they progressed down the items on the scale (these responses were omitted from the data analysis). Freeman (1988) found, in her study using a semantic differential, that disabled people were

seen as disadvantaged, dependent, of low status and unlucky. She concluded that the overall image of disabled people was patronising and paternalistic. Whilst the findings of this study do not match the negative images in Freeman's (1988) study, the over-positive view might be interpreted by some, especially disability activists, as a somewhat patronising and, therefore, oppressive image.

Positive attitude = empowering attitude?

Chapter 4 identified factors that might be seen as indicating a positive attitude towards disabled people. These factors included:

seeing disabled people as the same as non-disabled people;

seeing disabled people as equals and of equal status;

focussing on the person and her/his abilities;

acceptance;

not avoiding contact;

seeing disabled people as competent;

being prepared to defend the civil and social rights of the disabled individual.

Empowering attitudes were also outlined, and included:

equality;

equity;

choice;

respect;

civil rights;

acknowledging differences.

It was also proposed in Chapter 4 that the key measures of empowering attitudes, in this study, were the ATDP, the Suitability for OT Scale and the Disability Semantic Differential Scale. The findings of these Scales will now be reviewed in the light of these definitions of both positive and empowering attitudes.

The 'treatment' sub-scale of the ATDP was particularly identified as the part of the ATDP most relevant to measuring empowering attitudes. A high score on the 'treatment' sub-scale implies that the respondent perceives that disabled people should be seen as equals, given equal opportunities and treated with equity. The findings highlight a curious, and possibly worrying, difference between the OT student groups. The 3rd year OT student group holds significantly less positive attitudes than the other two OT groups. The 2nd year group, not surprisingly in the light of other findings, holds the most positive attitudes. Whilst in no way implying that the 3rd year OT group hold negative attitudes towards the equality of disabled people, it is somewhat concerning that these students, who are about to become qualified and practising OTs, hold the least positive attitudes towards the treatment of disabled people. This finding is in marked contrast with the qualitative findings, which showed that the students became more aware of client-centred practice towards the end of their studies. Perhaps this contrast reinforces the Internet discussion, cited above, of the need to address practice rather than to change attitudes.

The factor analysis of the ATDP data identified two factors that might be seen as highlighting empowering attitudes. These factors were 'competitive equality', which indicates attitudes related to treating disabled people with equity and equality; and a 'sense of self-worth', which can be linked with the notion of celebrating difference and disability.

The Suitability for OT Scale was identified as expressing empowering attitudes by acknowledging the right of disabled people to have access to OT as a profession. The interpretation and implications of these findings have been discussed above.

Key aspects of empowering attitudes are acknowledging the individual and acknowledging the differences between people, as well as valuing disabled people. These aspects can also be explored through the findings of the Disability Semantic Differential Scale. The profile of a disabled person constructed by the OT students using the semantic differential saw a disabled person as:

responsive;

having clear speech;

competent;

talkative;

valuable;

controlled;

trustworthy;

mature;

an asset to society;

socially skilled;

sensitive to others;

employable.

Aspects of this profile might be seen as reflecting an empowering attitude. Although the refusal of almost 10% of the sample to complete this part of the questionnaire, stating that it was impossible to generalise about individuals, might say more about empowering attitudes that recognise the value of the individual.

For the most part, therefore, it might be concluded that positive attitudes do equal empowering attitudes. However, it should also be noted that empowering attitudes are as complex as positive attitudes and that empowerment is expressed much more in action and practice than by the answers to a questionnaire. The qualitative data is where empowerment (or oppression) is expressed most clearly.

Attitudes in practice

The qualitative findings highlight a contrast between a professional practice, which focuses on the problems of the individual, and could, therefore, be oppressive, and a philosophy of practice, which is empowering and is based on giving clients choice and control. This reflects the contrasts within OT, and especially within OT theory. Reed and Sanderson (1995) focus on occupational performance and functional independence and this is reflected in the interview respondents' focus on functional issues when talking about

independence and successful treatment. However, the notions of client-centred practice which were articulated by Yerxa (1983) and refined and codified by Law et al (1995) were also apparent throughout the interviews and especially with the 3rd year students. These aspects of oppressive practice and an empowering philosophy of practice will be explored in more detail later in this chapter when we discuss the place of impairment within models of disability and OT, and then discuss definitions of oppression and OT.

DePoy and Merrill (1988) found that their students could articulate the values of OT but could not put them into practice. The results of this research would appear to be the reverse of this. By the time they reached the end of their degree studies the majority of students could put the values of patient choice and client-centred practice into practical situations. They were, however, unable to articulate clearly some of the values which underpin OT e.g. empowerment and independence, nor could they articulate and define some of the theoretical underpinnings of OT e.g. the social model. Perhaps this indicates that OT is, for these students, 'common sense'. As one respondent put it, OT was using

> *lots of big words ... 'cos we feel we should be more professional, because at the end of the day it's all common sense type stuff [3:4].*

This is, perhaps, an indictment of the focus of OT and OT education. Because OTs see themselves as practical people dealing with practical problems of daily living, there has been a tendency to neglect or play down the role and importance of theory and being able to articulate the theory

which underpins practice. As we have seen, for the most part, the ideas are there in practice but the students are unable to articulate them in theory.

For the most part, the students were not able to correctly define how the social model might influence their work as OTs. Those students who could articulate the role of the OT in the social model had both taken module 1528: Practice in Partnership (Disability) and had explored disability issues further in their dissertation research. The majority of the students saw the social model as focusing on the environment, but rather than talking about broader environmental issues they tended to focus on how an OT might help a disabled individual cope within their environment. Perhaps this is not surprising. OT, in general, has not really addressed the social model, as Craddock (1996a, 1996b) has highlighted. Although Yerxa (1980), over a decade ago, was pointing out that OTs had a role in changing the ways the medical professions and the general public viewed disabled people. Within the BSc (Hons) in Occupational Therapy the social model is presented in a number of modules but does not underpin enough of the thinking of the course for the majority of the students to have a sound grasp of the issues. Given the changing face of health and social care this is something that the Course should begin to address.

In the light of their somewhat limited grasp of the social issues of disability and the predominant focus of OT and rehabilitation on helping the person deal with her/his disability, it is not surprising that the majority of students tended to have an individualistic view of disability. However, as I will argue

later, there is a place for the individual and the consequences of impairment within the social model, and, therefore, a place for a non-oppressive view of OT.

This focus on the individual and her/his 'problems' also highlights a contrast between the personal and professional attitudes of the students. Vargo and Semple (1988) found that physical therapy students' professional attitudes were more positive than their personal attitudes. This research found that OT students' professional and personal attitudes were the same. In other words both personally and professionally OT students saw disabled people as no different from themselves. However, when these issues were explored qualitatively the picture is not as clear. The personal attitudes are, certainly, that disabled people are just the same as anyone else, and that the person should be seen before the disability. But when the students were talking about disabled people as patients or disabled people they see in the street, the majority of students mention the disability or 'condition' first. Thus indicating a professional attitude that does not see the disabled patient as any different from herself or himself, but rather focuses on the 'problem'.

A number of factors appear to be influential in determining students' attitudes towards disabled people and deserve some discussion here. The key factors appear to be, contact with disabled people; the stage of training, irrespective of age and gender.

Contact with disabled people has been clearly shown to have a major effect on attitudes towards disabled people (Altman, 1983, Yuker & Block, 1986, Furnham & Pendred, 1983, Strohmer et al, 1984, Donaldson, 1980, Lyons, 1990, Yuker & Hurley, 1987). However, as Donaldson (1980), Yuker and Block (1986), Furnham and Pendred (1983) and St Claire (1986) have highlighted, the nature of the contact and the status of the disabled person is crucial. The disabled person must be of equal status (Donaldson, 1980). This appears to be borne out in this research where contact with disabled people appears to influence attitudes in the main study, with 'having a disabled colleague' appearing to have the greatest effect. Thus reinforcing contact of equal status as the crucial factor. The lack of differences due to contact with disabled people in the personal/professional part of the study probably highlights the key difference between OT and non-OT students, and, possibly, one of the major factors in determining the attitudes of OT students towards disabled people, namely their contact with disabled people on an equal basis. However, the qualitative data highlights an interesting dilemma. Rothbart and John (1985) proposed that the most effective contact, for changing attitudes, was with an individual who achieved 'goodness of fit' with the majority of stereotypic notions of disabled people but who challenged one or two of these stereotypes. People, such as disability activists, who appear to challenge *all* of the stereotypical notions of disability might serve to reinforce attitudes, and this does appear to be the case for some students who took module 1528: Practice in Partnership (Disability) where two members of the module team are disability activists. This has implications for the teaching of this module and the Course in general. Students' attitudes

and ideas should be challenged, but perhaps the ways these ideas are challenged should be reviewed and re-assessed.

The majority of previous studies of OT students' attitudes towards disabled people have shown students becoming more positive as their training progressed (Westbrook & Adamson, 1989, Lee et al, 1994, Kirchman, 1987, Estes et al, 1991), although Lyons (1990) and Lyons and Hayes (1993) did not find significant changes. All of these studies were quasi-longitudinal in design, with Westbrook and Adamson (1989), Lyons (1990), Lyons and Hayes (1993) and Lee et al (1994) looking at students throughout their training. All of the studies where a difference was found indicated that the difference was progressive, 1st year to 2nd year to 3rd year. However this is not the case in the current study where the 2nd year group of students have the most positive attitudes. This might indicate that the learning experiences between the beginning of year one and the summer of year two are the most influential of the Course. This learning includes various opportunities for contact with disabled people, in module 1504: The Sociology of Impairment, Disability and Handicap, and two terms of Fieldwork Placement. What is also interesting is the slight decline in attitudes as the students near the completion of their training and prepare to work as OTs in the 'real' world. These findings may be an anomaly or may highlight the vital role played by module 1504 and Fieldwork in shaping students' ideas and attitudes. The qualitative findings do not, however, indicate such a dramatic change from year one to year two, the change appears to be more gradual and to evolve

over the three years, with a variety of key influences highlighted, including Fieldwork and Dissertation research.

Furnham and Pendred (1983) and Yuker and Block (1986) indicate that gender should not be a key variable in attitudes towards disabled people, although there were some indications that English research tended to find women more positive in their attitudes than men (Yuker & Block, 1986). This research has found some gender differences in attitudes, with male non-OT 1st year students holding the least positive attitudes. The implications of this have been discussed above.

The individual and the place of impairment

The focus on the individual and, therefore, the personal tragedy of disability, which has become apparent throughout this research, is the key factor in supporting the argument that OT and OTs are oppressive of disabled people. However if the focus is upon the impairment, or functional limitations, and the individual then the practice of OT might be seen in a less oppressive light.

Crow (1995) argues that whilst the social model of disability works well as a way of addressing issues and promoting radical change at a macro level, it fails at a micro level because it fails to 'include and represent fully the range of disabled individuals' (Crow, 1995: 6). She argues, very powerfully, that for disabled people, unlike any other oppressed group, the experience of their bodies is not neutral.

> There is nothing inherently unpleasant or difficult about other groups' embodiment: sexuality, sex or skin colour are neutral facts (Crow, 1995: 8).

Impairments can be painful, tiring, depressing and fluctuating. To ignore impairment is to ignore a large part of the subjective experience of disabled people, as well as ignoring the objective reality of functional limitation. Acknowledging impairment does not mean acknowledging the personal tragedy view of disability, but does highlight disabled people's experiences of their own bodies. By outlining these changes to the social model Crow (1995) has provided a way of articulating OT's non-oppressive approach to impairment.

The goal of OT treatment is 'independence' and, as we have seen, by the end of their training, the majority of students define independence in terms of 'choice' rather then in terms of 'functional achievement'. The goal of any individual, disabled or non-disabled, is choice and control over her/his own life. The role of the OT with any disabled person is to acknowledge her/his subjective experience of impairment and to address her/his functional limitations to facilitate choice and control over her/his own life. It is also to facilitate the removal of disability and disabling barriers for the individual and for disabled people as a whole. Thus OT has a role with both impairment and disability. However, the emphasis of intervention and the profession has been upon impairments and the individual and the Fieldwork experiences the students in this study will have had, will have served to reinforce the

individualistic approach and the apparent personal tragedy focus of the profession.

Crow (1995) acknowledges the problems for the social model of incorporating impairment, as it might be seen to reinforce personal tragedy views of disability. For OT the problem is the fine balance between functional limitation and subjective experience within the wider social view of impairment and disability, and the narrower view which sees impairment as part of the personal tragedy of the disabled individual and, therefore, the cause of all of their problems and limitations. By focusing on functional independence we reinforce the oppressive nature of OT.

The goal of the model, which is discussed later in this chapter, is to provide OTs with a way of articulating where their practice can address impairment and where it addresses disability. The philosophy of client-centred practice is central to the notion of OT as an empowering profession, whatever model of disability is being used.

Definitions of oppression

As was discussed in chapters 2 and 3, oppression can be defined in terms of inequalities of power, of constraints placed by one group upon another group, and, with specific reference to the oppression of disabled people, the emphasis upon 'normality'. In chapter 3 the potential for OT to be both oppressive and empowering was discussed.

The findings of this study appear to indicate that, by the end of their training, the majority of OT students are less oppressive and more empowering. They are aware of inequalities between clients/patients and therapist and work to reduce this. They are aware of the tyranny of 'normality' and will, for the most part, work towards the client's/patient's, rather than their own, therapeutic goals.

Their practice is empowering, as they talk about their practice in client-centred terms. However, as Ward and Mullender (1993: 148) point out, ideas and words 'cannot provide an adequate foundation for practice'. It is not enough to use these terms when talking about their practice. To be truly empowering OTs must be able to define and understand the causes of oppression and the principles which underpin empowerment. However, as this research has shown, student OTs have a tendency to be atheoretical. They can use principles of empowerment or the social model of disability when they talk about a practical situation, but they cannot define what the terms mean, or the principles surrounding them, and so their practice lacks any theoretical depth. It can only be inferred that this must also be the case for OTs in practice and OT faculty. If the students had been able to see role models on Fieldwork or in College putting ideas into a theoretical construct then they, themselves, might be able to underpin their practice with theory. Without a sound grasp of the theoretical issues, of the nature of the power which oppresses disabled people, these students will be unable to work effectively with their disabled clients to challenge the disablist environment. They will be in severe danger of becoming oppressive practitioners.

The definitions of oppression discussed previously tended to assume that a personal tragedy/individualistic/medical model/impairment focused view of disability was inherently oppressive. However, this research has begun to question this. The interviewees in this study seem to hold conflicting ideas. They see disabled people as no different from themselves. They understand issues of power. They talk about the practice of OT in client-centred terms. Yet they also talk about the problems of a disabled individual. They appear to be oppressive and empowering at the same time.

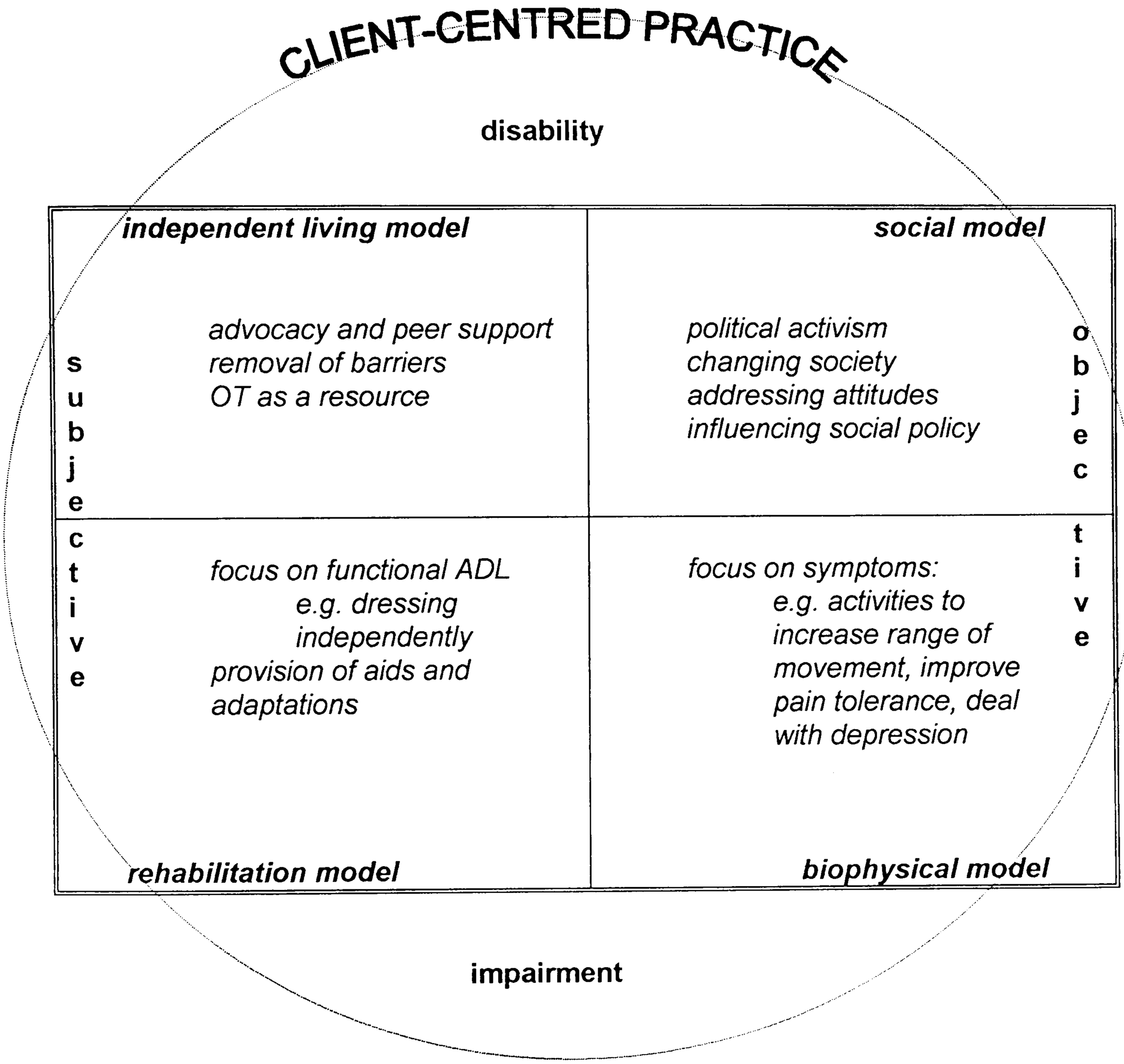
This appears to contradict the notion of oppression and empowerment as a duality or continuum, with oppression at one pole and empowerment at the other. Post-modernist thinkers have argued against other dualities e.g. male/ female, health/illness. So with oppression and empowerment. They are not a fixed duality, but fluid and in a constant state of flux. The notion of being oppressive *or* empowering is too simplistic. What might be oppression to one person may be empowering for another.

For OT the central tenet is to be client-centred. By focusing on the client's needs and her/his perceptions of what is problematic the therapist can work towards addressing the key issues of empowerment for that client. For some disabled people this might be through changing the external environment and social oppression, but for others it will be by focusing on their impairment and dealing with their personal tragedy. Client-centred practice becomes a way of viewing and re-interpreting oppression and empowerment.

A lens to see through

Drawing together the various strands of this research it is possible to utilise, and re-interpret, Burrell and Morgan's paradigms to create a way of conceptualising OT interventions with disabled people, to provide OTs with a lens through which to view their practice, or a way of articulating that practice. Figure 8:1 illustrates this conceptualisation, encompassing the paradigms and models of OT intervention within an overall philosophical framework of client-centred practice.

Figure 8:1: A conceptual framework of occupational therapy intervention



The potential for OTs to work with issues of impairment, or functional limitation, and issues of disability has already been established and this is reflected in Figure 8:1, where the models of OT appropriate to impairment and disability issues are identified. The biophysical and rehabilitation models have their roots in traditional health care/hospital practice and its approach to

the individual's 'problems'. This might be seen in terms of an oppressive, personal tragedy view of disability. However, within this conceptualisation, the focus is on the objective functional limitations and the subjective reality of the individual. The guiding principle is client-centred practice. Thus it is for the therapist, guided and directed by the client, to identify the areas of functional limitation which need to be addressed, and which aspects of the subjective experience of impairment the client wishes to find ways of combating with the help of her/his OT.

The need for impairment to be included in the experience of disabled people has been discussed above. For some disabled people the problems caused by their impairment may be their primary need and focus of concern. From a biophysical (medical) perspective this could be due to symptoms of pain, limited range of movement or depression. From a rehabilitation perspective it could be the client's desire to function independently. Both of these perspectives address the impairment. However, if these are the areas that the client wishes to address, this cannot be oppressive practice.

The independent living and social models have closer links with social care practice, but should have relevance for all areas of OT practice. Here the focus is on disability and the role of the OT as a resource and an ally in addressing and removing the disabling barriers and disabling policies and practices within society. This might mean working in an independent living framework as a resource for disabled people. It might mean a more radical approach, working within a social model perspective and working with

disabled people to influence social policy. If the OT's agenda, rather than the client's drove either of these activities, they could be as oppressive as any individual, personal tragedy approach.

This framework attempts to locate the various models of disability and OT practice within a coherent scheme. The central dimension of the framework is impairment and disability. This has replaced oppression and empowerment, which, as we have seen, is an outmoded duality. The framework attempts to identify how each model can address the problems of impairment or disability. However, without the lens of client-centred practice any of the models could be oppressive. It is hoped that the framework will provide a means of explaining and articulating the theory that underpins practice. By doing this it should provide a tool for teaching and assessing students both in College and on Fieldwork. These ideas will be discussed further below.

If we reassess the responses of the students in this study in the light of this conceptual framework, we find that the majority of the students are taking impairment and functional limitation as their focus of intervention. However, for the most part, this was within a client-centred perspective and was, thus, more empowering than oppressive. Some of the students were able to explore the role of OT intervention for both impairment and disability, but these students are in the minority and tend to have had social services as well as health care Fieldwork experience and also had taken 1528 as one of their acceptable modules. Thus reinforcing the importance of Fieldwork and

interaction with disabled people as colleagues, and teachers, in influencing attitudes and thinking amongst OT students.

This framework could, however, still be seen to underpin an individualistic and oppressive approach to practice if the all-encompassing guiding principle of client-centred practice is ignored. As we have seen the majority of students are able to frame their practice within a client-centred philosophy, but they are not always able to articulate the ideas which underpin their practice. Any OT intervention should be client-centred and, by using these principles together with the models outlined in Figure 8:1 any OT intervention should be empowering rather than oppressive. In chapter 3 the case history of a person with a spinal cord injury was used to illustrate OT interventions. This case history, together with the case history scenario used throughout the interviews in this study, will now be used to illustrate how the conceptual framework in Figure 8:1 could guide and help the articulation of OT intervention.

For the young man, newly admitted to a Spinal Injury Unit, the place to begin would be with his symptoms and subjective reality of his impairment. This could well include pain, low mood, disorientation as well as the limitations in movement, which are a direct result of the severance of the spinal cord. OT intervention would, at this stage, be the use of occupations to help the young man address these symptoms (the biophysical approach). If this client's goal was to be able to spend some time of every day standing upright this intervention approach would be empowering him in attaining this goal rather

than oppressing him by 'forcing' him to attain 'normality'. Once he was beginning to mobilise, the OT would explore with him the functional limitations resulting from the spinal injury and ways of becoming as functionally independent as he required (the rehabilitation model). Again, the client's goals will determine whether this intervention approach is empowering or oppressive. Independence may not be achieved without changes to his home, social and work environment in the form of employing personal assistants or adapting the physical environment (the independent living model). However, becoming the employer of a personal assistant may appear a daunting task and may be interpreted as an oppressive rather than an empowering activity by the client. Being able to take part in all aspects of life and taking part in any meaningful occupations may involve challenging societal attitudes and presenting a positive image of disability (the social model). This again highlights the potential conflict of empowering and oppressive perspectives. Not all clients wish to be seen as disability activist or as positive images of disability. Being expected to be an activist or a role model could be as oppressive as it is empowering for some clients.

The OT intervention with the 30-something lady with RA who thought getting herself dressed was a waste of valuable energy could also be articulated using the framework. Again the place to begin would be with this lady's subjective experience of RA and to review her symptoms (the biophysical model) and her functional limitations (the rehabilitation model). Her symptoms of pain, fatigue, low mood and reduced range of movement will impact on her functional limitations and, with the OT, she will identify which symptoms and

functional limitations can be addressed through OT intervention. This may well mean not dressing herself and, therefore, she and the OT will have to explore ways of finding alternative sources of physical help for those personal care activities which are too energy consuming (the independent living model). It may also mean taking part in direct action to highlight the access needs of disabled people in the local area (the social model). The key issue is for any intervention to be client-centred and to be fulfilling the client's goals rather than fulfilling the goals or needs of the therapist. The ability of the rehabilitation approach to be oppressive was clearly demonstrated by responses such as

> *... if you don't dress yourself, you will be very limited, because you can't do many things without your clothes on, so it would be a case of having to if you want to be perceived as anywhere near normal then you've got to put your clothes on [1:5].*

Although, as we have seem, this was not the view of all of the respondents

> *firstly I'd find out what they meant by they don't want to ... bearing in mind that they may not want to do it there and then, or they may be wanting to conserve energy and so would say 'to me that's not important, I'd much rather .. go swimming twice a week but get someone else to get me dressed', so I'd find out where they stood .. on that ... because at the end of the day it's their choice .. [3.1].*

Using this framework will not always be easy, as conflict is inherent within it. Whilst the biophysical model might appear to be mirroring the medical model, the principles behind it are profoundly different. The medical model, with its

emphasis on cure and normality, is often seen as inherently oppressive of disabled people. The biophysical model, whilst it is focusing on symptoms-based interventions, is driven by the disabled person's perceptions of needs and problems and so is empowering. Similarly, the rehabilitation model is focusing on functional limitations but is not driven by the need to be functionally independent, the disabled person sets the agenda and establishes her/his own parameters of independence. The independent living and social models will result in conflict because of the need for and the limitations placed upon the availability of resources, such as funding for major adaptations to housing or the funding of personal assistants. Government and local authorities have proved very reluctant to allow disabled people to have control over the finances for adaptations or assistance, thus reinforcing the oppression of disabled people. OTs will have to challenge these to be truly empowering of their disabled clients. DePoy and Merrill (1988) found that the OT students in their study thought that client-centred values were all very well in theory, but that in practice they were difficult to apply. However, as we have seen in this study, the majority of OT students have shown that they are prepared to work on behalf of their disabled patients and clients and to challenge the system where necessary. This framework should give them the tools to be able to articulate their challenges.

Implications of this research

Whilst this research is not without its flaws, which have been discussed above, it does offer useful insights into the ways OT students think. The implications of the research will be discussed in three areas beginning with

the implications for the professional education of OT students. The implications of the research to the developing area of disability sociology and theory will then be discussed. The section will conclude by looking at the implications in terms of research that might be done to follow-up this research.

Professional education

One of the original aims of this research was to develop guidelines for professional education to facilitate the development of professional attitudes towards disabled people. A second aim was to develop a theory of professional action, particularly focusing on a way of conceptualising OT interventions with disabled people.

The research has noted that OT students hold positive attitudes towards disabled people, which do not change dramatically as their professional socialisation progresses. However, their ability to translate these attitudes into practice and especially to articulate the theories and values that underpin practice is somewhat limited. The research process, as a whole, has been used to develop a framework of practice, which identifies the intervention approaches that are appropriate for looking at impairment [the biophysical and rehabilitation approaches] and those that are appropriate for dealing with disability issues [the independent living and social model approaches] and has placed all of these within an overview of client-centred practice. It is this framework which has the greatest implications for professional education.

The framework should provide a tool for teaching. By using the framework as a way of explaining and articulating how the various intervention approaches can be used with one client, it should provide students with a clearer understanding, and ability to articulate, the theoretical framework that underpins their practice. By identifying the complexities of empowering and oppressive intervention the model can provide students with an understanding of how the values and theories of OT can work to empower their disabled clients.

Providing a tool, or framework, that helps students to articulate their practice will be invaluable, DePoy and Merrill (1988) found that students had problems putting the values of OT into practice. This study found that students had problems articulating the theoretical context of OT. The framework that has been developed within this research should overcome both of these issues by providing students with the conceptual tools to explain the practice of OT.

Earlier in this chapter the framework was used to illustrate how the different intervention approaches might be used during the rehabilitation of a young man with a spinal cord injury, and to highlight how each approach could be, potentially, both empowering and oppressive. This task could provide the basis for discussion with groups of OT students, to provide them with opportunities to explore how different intervention approaches might be used and to explore the oppressive and empowering potential of OT practice.

The research has also illustrated the impact of contact with disabled people on the attitudes of OT students. Both the qualitative and quantitative aspects of the study demonstrated the value of contact. Students with more contact, especially with disabled peers and colleagues, tended to hold more positive attitudes. Students, in the interview cohort, who had contact with disability activists, either on Fieldwork, through module 1528: Practice in Partnership, or their Dissertation research, tended to have the clearest grasp of issues related to empowerment and the social model of disability. This would appear to highlight the need for contact with disabled people as a central part of the professional socialisation process. It must be noted, however, that this contact needs to be with disabled people who are perceived as equals and who challenge, within a supportive environment, the stereotypes of disability. The need for the supportive environment was highlighted by a number of respondents, both to the main interview and the 1528 interview. These respondents reported feeling threatened rather than challenged by the disability activists teaching on that module. This tended to have an effect that was more negative than positive. However, contact, in some form, should not be neglected in the professional socialisation process.

Disability theory

Whilst this research did not set out to change the course of disability theory, nor can it be said to have identified any groundbreaking insights for disability theory, it has reinforced the existing debate about the need to explore issues of impairment as well as disability in order to understand the totality of experience of disabled people. It has also highlighted the complexity of

oppression and empowerment, both as concepts and as factors within professional practice.

By highlighting the role of OT intervention with both aspects of impairment and disability, this research has added to the debate initiated by Crow (1995). Crow has argued that the experience of impairment must be included within the analysis of the experiences of disabled people. This research has sought to provide OT students with a way of articulating their role in interventions dealing with both impairment and disability. The research has also highlighted the notion that both impairment and disability have a subjective and an objective reality. Again to understand the disability experience, both of these perspectives must be acknowledged and explored. Acknowledging the objective reality of disability, in terms of inequality, and of impairment and, in terms of the presence of symptoms, may also extend the feminist analysis of disability, which has tended to focus more on the subjective reality of the disability experience.

The complexities of oppressive and empowering practice have already been discussed. The impact of this research on the conceptual understanding of oppression and empowerment will now be explored. The inference, from the previous literature, has been that oppression and empowerment form opposite ends of a duality. As has been previously discussed, this does not seem to be the case; oppression and empowerment are not static. Oppression and empowerment are as much individual perceptions as they are theoretical concepts. What one person sees as oppressive, may well be

seen as empowering by another. The case of people with spinal cord injuries attempting to stand and to walk is a case in point. From the perspective of disability activists this is because of an oppressive expectation to be 'normal', for the person concerned it is the empowering perspective of being able to reach all of the cupboards in the kitchen or stand at the pub bar with her/his friends.

Future research

A number of directions for future research are indicated by this study and its findings, these focus on exploring the value of the framework and on continuing to explore attitudes towards disabled people.

The findings highlighted a potential difference between the attitudes of OT and non-OT students. However, the non-OT data were flawed and so these results should not be accepted at face value. Previous research has also had mixed results when comparing OT and non-OT student groups. No previous research appears to have been conducted in the UK. It would, therefore, seem useful if a more rigorous sample of non-OT students were surveyed to provide comparative data. The key task for any future research would be to find an appropriate tool to measure attitudes, as the flaws of the ATDP have already been discussed. This tool could also be used to explore the attitudes of qualified OTs. Some research has been done in this area (e.g. Benham, 1988) but, again, nothing has been carried out in the UK. Benham found that attitudes varied depending on how long the respondent had been qualified. Given the changes in attitudinal climate and ideas about OT practice, it might

be interesting to compare the attitudes of OTs who qualified recently with those of OTs who have been qualified for some years.

The interview data highlighted the emphasis on functional definitions of independence within OT practice. These definitions appeared to have been reinforced by the respondents' experiences of OT whilst on Fieldwork. This implies that qualified OTs are working with individualistic and possibly oppressive perspectives of practice. This perception has been reinforced in a number of discussions of this research with groups of OTs. It might be interesting to repeat the interviews with qualified OTs to explore whether their practice is oppressive.

One of the areas explored in this research was how open OTs are to seeing disabled people train to become OTs. Discussing this issue with colleagues raised the question of whether disabled OTs experience any prejudice. This opens a potentially interesting avenue of further research, into the experiences of disabled OTs. Three areas need to be explored. The first is to continue using the Suitability for OT Scale and to gather data from a variety of practising OTs. The second is to explore the practicalities of training as an OT in the UK. Drawing on my own experience, whilst we might welcome students with mobility impairments, the practicalities are that access to computer facilities, professional tutors and some teaching rooms would be impossible as there is no lift access from ground to 1st floor. The third aspect of further research in this area would be to explore the experiences of disabled OTs by interviewing OTs with a variety of impairments. Personal

communication with a number of disabled OTs indicates that they have experienced oppression, and oppressive attitudes, in the workplace. The DDA (Disability Discrimination Act) is in force. It would be interesting to explore whether it has made any difference to the working lives of disabled OTs.

The research has attempted to develop a framework which conceptualised the place of OT with both impairment and disability. The value of this framework is as a teaching tool to help students to understand and articulate the use of a variety of intervention models. The framework has been developed; it now needs to be tested in practice. Research now needs to be carried out to see whether the framework can provide a useful teaching structure and can help students to understand and articulate the concepts that underpin their practice. The framework also needs to be explained to practitioners to see if it has value for their interventions. The framework needs to move beyond the theoretical and to be used as a practical reasoning tool.

Critical reflections

As the study draws to an end, it is the place to look back over the 7+ years of the research and reflect critically on the process which has led to the development of the conceptual framework outlined in the previous section. When I set out on this process in 1991 my goal was to understand professional attitudes towards disabled people within the context of professional socialisation; I had no idea that this would lead to the

development of a conceptual framework for OT intervention with physically disabled people. The process of research has also been a voyage of discovery and of development in terms of my knowledge about professional attitudes and issues of empowerment and oppression but also about OT, my skills as a researcher and my thinking as a researcher, a disability sociologist and an OT.

The use of an integrated methodology allowed me to develop skills in both qualitative and quantitative research. It also allowed the flexibility for the research to develop as the study progressed. The interview themes were expanded and a variety of questionnaire tools were used with different groups of students.

The complexity of the concepts of oppression and empowerment became clear as the study progressed. At the beginning of the research it seemed clear and simple. The social model of disability equalled empowerment, whilst the medical model was synonymous with oppression. As the research progressed it became apparent that both perspectives had the potential to be empowering or oppressive. It is hoped that the research has reflected this challenging view.

The use of the case study approach has not been easy. As with much qualitative and integrated research, the case study process is not defined. It is a process which has evolved and changed as the study grew and developed, and as such, was the ideal approach. The fact that the research

has evolved and changed as it progressed should not be seen as a weakness but as a strength. The process has been open and flexible to allow for the study to evolve as the researcher's thinking has evolved. The main focus of the study was longitudinal, following one group of students throughout their OT training, thus allowing true comparisons to be made, as these students' ideas changed and developed. I do, however, feel very sorry for this particular cohort of students at having to complete *so* many questionnaires and to be interviewed quite so many times. The aim for a truly longitudinal study became impossible and the compromise approach of a quasi-longitudinal design had to be adopted. In an ideal world all respondents would return every questionnaire. Research, however, does not happen in an ideal world and compromise is, therefore, necessary.

The various data collection methods are not without their limitations, as has been demonstrated in this study and discussed in this chapter. Questionnaires are excellent for gathering relatively large amounts of data relatively quickly. However, having a 'tame' group of respondents is always a great advantage. It was very easy to collect data from the OT students and to follow-up any non-responses. It was far more difficult to collect data from non-OT students. Having no direct access to groups of non-OT students, I had to rely on the good offices of colleagues to distribute and collect the questionnaires. Whilst colleagues always had good intentions of helping with the research, it was not their research and so their commitment to achieving a 100% response rate was not as strong. The response rate from non-OT students is low and insufficient to establish differences between OT and non-

OT students. More data should be gathered if the questionnaire were to be used as a screening tool for potential OT students, as Benham (1988) suggests. More research needs to be carried out to identify the appropriate research tool for a screening task. Any screening tool would need to include aspects beyond attitudes towards disabled people and is beyond the scope of this research.

Questionnaires are also a useful tool for gathering large amounts of quantitative data about attitudes. Sadly, quantitative scales are rarely subtle enough to do more than present very general views and this can be frustrating for both the researcher and the respondent. The semantic differential part of the main questionnaire is a case in point. Whilst the majority of respondents completed this task, a sizeable minority either refused to complete this section, saying it was impossible to generalise, or refused to generalise by choosing a mid-point on the scale. However, this section of the questionnaire did give interesting insights into the image and stereotype OT students have of disabled people. None of the measurement tools used was perfect. The flaws have already been discussed. However, the data has given a picture of OT students' attitudes towards disabled people.

Interviews also have their strengths and weaknesses. The strengths are the depth of information that can be gleaned. The weaknesses are that the relationship between the respondent and the researcher can get in the way of the data. The potential was inherent for the tutor/student relationship to

contaminate the researcher/respondent relationship, but it never seemed to in this case. Students were amazingly honest in their responses, and there was never the sense that respondents were searching for the 'right' answer. Interestingly, the students also respected this and rarely asked me about the research outside the interview, whether they talked about the research amongst themselves, I am not sure. Interviewing is a skill and, perhaps, the greatest skill is in asking good probing questions and following up comments to explore the true meaning of the response. As I re-read the transcripts I was very aware that this was not always one of my strengths as a researcher.

It might have made the data more robust if there had been more respondents. However, the time constraints were such that more interviews were not possible. The respondent group did, however, provide a useful snapshot of that particular cohort of students. Again, in an ideal world, it might have been possible to follow-up the interview group and talk to them one year on from qualification. However, students are notoriously poor at giving accurate follow-up details and so follow-up interviews were not deemed possible.

Research is a time-consuming occupation. The goals of any OT intervention are to facilitate independence and to help the client to achieve a measure of balance between the occupational behaviours of self-care, productivity and leisure. One of the hardest tasks of these 7+ years has been to balance self-care, productivity and leisure sufficiently to find space for the research. I suspect that leisure has suffered and I have rarely achieved the balance of

occupations that is the goal of any OT intervention. I have not always managed to put into practice what I know to be true in theory.

Conclusions

This research has culminated in the development of a conceptual framework for OT intervention with physically disabled people, thus fulfilling the aim of developing a theory of professional action. Professional attitudes towards disabled people have been thoroughly explored and it has been established that, whilst for the most part OT students' attitudes towards disabled people are positive and empowering, they do hold attitudes which could potentially be oppressive. The research has also shown the complexity of attempting to conceptualise and measure empowering and oppressive attitudes.

The implications of this research for the teaching of OT students are clear. The conceptual framework can provide a framework and a focus for teaching and a means of helping students to articulate the values and principles underpinning their professional judgements. The framework identifies impairment and disability and the particular intervention approaches that are appropriate not only to impairment or disability but also to particular subjective or objective aspects of impairment or disability. The framework can be used to underpin a developmental process in teaching. Beginning with the 'symptoms' and subjective reality of the impairment and the functional limitations for the impaired individual, before progressing on to explore the impact of disability for the individual and society and ways in which the OT can act to reduce disability. As we have seen, some students do not move

beyond the focus on impairment, but by using this framework it is hoped that all students will appreciate the role they have in helping disabled people to lessen the impact of impairment and disability.

The framework has been designed specifically with physically disabled people in mind. Conceptualising the role of OT with other client groups is equally complex. It might be a useful extension of this work to explore how this framework might be reviewed and re-interpreted to conceptualise OT intervention with other client groups (e.g. people with mental health problems),

The research also has implications for the profession of OT. As Craddock (1996a, 1996b) has highlighted, OT, particularly in the UK, has failed to address the issues raised by the social model of disability and the disability movement. This study goes some way to redress this by providing a framework for OT intervention which acknowledges the goals of the disability movement and the role of the social model in understanding disability. It should challenge our thinking. An interesting follow-up, to this research, would be to present qualified OTs with similar scenarios and questionnaires to those given to the OT students to see if attitudes in practice are as empowering as the attitudes of the practitioners of tomorrow. One suspects that they may not be.

The research is not perfect. The flaws have been reviewed and discussed. However, the research has achieved its aims and answered its research

questions. A framework for professional action has been developed. The value of that framework must now be tested in the real worlds of OT education and OT practice.

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APPENDIX

Appendix I: Overview of the BSc(Hons) in Occupational Therapy

(from BSc(Hons) in Occupational Therapy course handbook, 1992)

STAGE I (YEAR 1)

During the first year of the course, students will acquire knowledge, skills and competencies through the study of:

COMPULSORY MODULES:
1500 - Human Biology in Health and Disease (double module)
1501 - Foundations of Human Behaviour
1502 - Theories, Models and Practice of Occupational Therapy
1504 - Sociology of Impairment, Disability and Handicap
9208 - Measurement and Analysis in Social Enquiry

ACCEPTABLE MODULES:
1503 - Activity : Properties and Processes
1505 - The Rehabilitative Approach to Dysfunction
1506 - Fieldwork 1 (double module)
1507 - Fieldwork 2 (double module)
NB: at least one fieldwork module MUST be passed

In order to proceed to Stage II, i.e. years 2 and 3 of this degree course, students are required to take 12 Stage I modules and pass.

STAGE II ADVANCED LEVEL (YEARS 2 & 3)

Students for an honours degree, will normally study 20 advanced modules and must pass 18.

For an unclassified degree, students will normally study 18 advanced modules and must pass 16, including all compulsory modules.

In collaboration with their professional tutors, students may choose from a selection of acceptable modules, some of which are specific to the field and some of which are available from the pool of modules within the University's modular course.

For the Occupational Therapy degree course students are currently required to take the 12 COMPULSORY modules that are specific to this course of study.

COMPULSORY MODULES:-
1510 - Functional Adaptation
1511 - Human Occupation: a Model of Practice
1512 - Fieldwork III (double module)
1513 - Therapeutic Engagement: the Practice of Occupational Therapy
1514 - Accessible Environments

1515 - Fieldwork IV (double module)
1516 - Management in Health Care Contexts
1517 - Neurological Impairment
1524 - Research in Professional Practice
1597 - The Occupational Therapy Process: a Synthesis of Practice
1598 - Project/Dissertation

ACCEPTABLE MODULES:-
1518 - Issues in Health Care
1519 - Biomechanics and Kinesiology
1520 - Hand Rehabilitation
1521 - Cognitive Dysfunction and Developmental Impairments
1522 - Independent Study in Applied Activity and Design
1523 - Groups: Theory and Process
1525 - Working with Children and their Families
1526 - Working with Elderly People and their Carers
1527 - Information Technology and Communication
1528 - Practice in Partnership (Disability)
1016 - Health of Nations
1243 - Mental Health and Social Policy
1261 - Learning Disabilities: Policy and Practice
1918 - Mental Health and Professional Practice

FIELDWORK EDUCATION

Fieldwork experience aims to:-

- extend knowledge, skills and competencies acquired during academic study;

- develop attitudes necessary for professional practice;

- manifest integration of theoretical and practical components of the course.

Students have the opportunity to work in different settings of care with people of varying ages who have a variety of diagnoses and functional deficits. Placements for each student are aimed to provide a balance of experience across the range of Occupational Therapy Services provided for people with physical/psychosocial dysfunction, learning disabilities or multiple impairments in a variety of settings of care.

Structure

Fieldwork placements are positioned throughout the course with specific aims and objectives for each stage. Knowledge, skills and competencies gained during fieldwork are integrated into subsequent modules.

Rationale

Stage I (Year 1): In Modules 'Fieldwork I' (1506) and 'Fieldwork II' (1507), the student is expected to investigate service delivery in two contrasting therapeutic settings. In each setting the student explores service delivery from two perspectives - that of the client and that of the professional.

Stage II (Years 2 & 3): In Module 'Fieldwork III' (1512), the student is expected to build on knowledge, skills and competencies gained from Stage I modules, as well as from Stage II modules studied to date. Emphasis is placed on the student integrating the theory and practice of occupational therapy in a defined field, examining different assessment procedures through a comparative study, and engaging in further exploration and acquisition of professional skills and attitudes.

In Module 'Fieldwork IV' (1515), the student works in a contrasting field of practice to 'Fieldwork III', and is expected to build on acquired professional knowledge, skills and attitudes, and concentrate additionally on the management perspective of care delivery.

Brief Descriptions of modules

1500 "Human biology in health and disease"
An introduction to human anatomy and physiology, including selected pathological conditions.

1501 "Foundations of human behaviour"
An introduction to the study of human behaviour, concentrating upon the personal and social factors influencing the development of the individual, and their relevance to the work of the occupational therapist.

1502 "Theories, models and practice of occupational therapy"
A review of the history, development and philosophy of the profession of occupational therapy and of concepts guiding current practice. Contexts of health care delivery and the art of occupational therapy practice will be examined.

1503 "Activity: properties and processes"
This module is designed to provide acquisition of foundation skills in the range of activities relevant to occupational therapy practice. It is concerned with the analysis, graded application and evaluation of goal-directed activity.

1504 "The sociology of impairment, disability and handicap"
Sociological analysis of lay and professional approaches to impairment, disability and handicap.

1505 "The rehabilitative approach to dysfunction"

Exploration of the rehabilitative model to dysfunction, utilising a client centred approach.

1506 "Fieldwork I"

This module will enable the student, under supervision, to observe, participate in and reflect on the practice of occupational therapy in one of two contrasting fields of work.

1507 "Fieldwork II"

This module will enable the student, under supervision, to observe, participate in and reflect on the practice of occupational therapy in one of two defined fields of work, for example: physical dysfunction, psychosocial dysfunction or learning disabilities.

1510 "Functional adaptation"

An examination of methods of functional adaptation for clients with physical and psychosocial dysfunction.

1511 "Human Occupation: a model of practice"

An exploration of the model of human occupation as a framework for clinical decision making in occupational therapy.

1512 "Fieldwork III"

This module will enable the student to participate in and reflect on a further period of fieldwork in a different area of occupational therapy practice from earlier fieldwork experiences. The student will progress from guided participation to independent practice in a hospital, community or personal social services setting of care.

1513 "Therapeutic engagement: the practice of occupational therapy"

This module is designed to enable synthesis of theoretical knowledge with the art of practice and develop skills of clinical reasoning.

1514 "Accessible environments"

An examination of the philosophy, legislative background and implementation of the Care in the Community policy and the contribution of the occupational therapist in creating and developing an accessible environment.

1515 "Fieldwork IV"

This module will enable the student to participate in and reflect on a further period of fieldwork in a contrasting field of occupational therapy practice from Module 1512 "Fieldwork III". The student will progress from guided participation to independent practice in a hospital, community or personal social services setting of care.

1516 "Management in health care contexts"

A critical examination of management principles and practice in the context of health care provision and the furtherance of knowledge and skills necessary for effective service delivery.

1517 "Neurological Impairment"
This module aims to apply developmental and neurodevelopmental theory and principles to the Occupational Therapy process with both children and adults who have neurological impairments.

1518 "Issues in health care"
Peer group exploration and analysis of a selected topic or specialism in health care, undertaken in workshop sessions.

1519 "Biomechanics and Kinesiology"
The application of mechanical principles to human posture, movement and remedial treatment.

1520 "Hand Rehabilitation"
This module is designed to explore specialist treatment techniques in the management of hand conditions.

1521 "Cognitive dysfunction and developmental impairments"
This module aims to explore normal cognitive and neurodevelopmental processes, leading on to an investigation of the changes which occur in these processes with various dysfunctions

1522 "Independent study in applied activity and design"
An opportunity for supervised investigation of the therapeutic relevance of a selected activity and the design of equipment to meet a specified functional requirement.

1523 "Groups: theory and process"
An exploration into the theory, process and practice of psychodynamic and contemporary group work.

1524 "Research in professional practice"
This module aims to provide a sound theoretical basis for professional research. It will give the student practical experience in the critical review of published researched literature, and in the design of a research proposal in preparation for the dissertation module.

1525 "Working with Children and their Families"
An exploration of clinical and management issues in relation to working with children with disabilities and their families.

1526 "Working with elderly people and their carers"
This module is designed to increase knowledge of human ageing and an understanding of the role of the occupational therapist working with the elderly person in a range of settings of care.

1527 "Information Technology and Communication"
This module addresses the application of Information Technology in Health and Social care and examines alternative and augmentative communication.

1528 "Practice in Partnership (Disability)"
A module to prepare students to work in an effective partnership with disabled people, those close to them, and other agencies with the objective of empowering disabled people to achieve or maintain the quality of their chosen lifestyle.

1597 "The occupational therapy process: a synthesis of practice"
Consolidation of knowledge and skills, focusing on client/patient groups relevant to current practice. Opportunities to develop skills of clinical reasoning, problem solving and critical appraisal.

1598 "Project/Dissertation"
An individual critical investigation, research project and written presentation of a topic, theme or issue, selected by the student with relevance to themselves as an Occupational Therapist.

9208 "Measurement and analysis in social enquiry"
This module is designed to familiarise the student with elementary skills of data measurement and analysis. The emphasis throughout will be on the utility of these skills in the student's field of study, on their practical implementation and on the meaning and interpretation of results.

1261 "Learning Disabilities -policy and practice"
An overview of issues in relation to care provisions for people who have learning disabilities including those arising from legislation, history and the development of services.

1016 "Health of Nations"
This module looks at concepts of Health & Disease and problems of measuring the health of communities.

1243 "Mental health and social policy"
Sociological analysis of the development of policies for the mentally ill in Britain.

Appendix II: Pilot Study Questionnaire 1

Thank you for taking the time to complete this questionnaire. All the information will be confidential, the use of your University number is only to make comparison with a second questionnaire possible and the number will be removed before the information is processed.

University Number .....

Please circle the category which most fits your opinion for each of the following statements, e.g.

strongly agree agree don't know disagree strongly disagree

1. Physically disabled people are just as sensible as other people.

strongly agree agree don't know disagree strongly disagree

2. Parents of physically disabled children are less strict than other parents.

strongly agree agree don't know disagree strongly disagree

3. Physically disabled people are usually easier to get along with than other people.

strongly agree agree don't know disagree strongly disagree

4. Most physically disabled people feel sorry for themselves.

strongly agree agree don't know disagree strongly disagree

5. Most physically disabled people worry a great deal.

strongly agree agree don't know disagree strongly disagree

6. Physically disabled people are just the same as anyone else.

strongly agree agree don't know disagree strongly disagree

7. There shouldn't be special schools for physically disabled children.

strongly agree agree don't know disagree strongly disagree

8. You have to be careful of what you say when you are with physically disabled people.

strongly agree agree don't know disagree strongly disagree

9. Physically disabled people are as happy as other people.

strongly agree agree don't know disagree strongly disagree

10. Physically disabled people cannot have a normal social life.

strongly agree agree don't know disagree strongly disagree

11. Severely disabled people are no harder to get along with than those with a minor disability.

strongly agree agree don't know disagree strongly disagree

12. Physically disabled people tend to keep to themselves much of the time.

strongly agree agree don't know disagree strongly disagree

13. Physically disabled people are more easily upset than other people.

strongly agree agree don't know disagree strongly disagree

14. It would be best for physically disabled people to live and work in special communities.

strongly agree agree don't know disagree strongly disagree

15. Most physically disabled people feel that they are not as good as other people.

strongly agree agree don't know disagree strongly disagree

16. It is up to the government to take care of physically disabled people.

strongly agree agree don't know disagree strongly disagree

17. Physically disabled people should not be expected to meet the same standards as other people.

strongly agree agree don't know disagree strongly disagree

18. Physically disabled people are often cross.

strongly agree agree don't know disagree strongly disagree

19. It is almost impossible for a physically disabled person to lead a normal life.

strongly agree agree don't know disagree strongly disagree

20. You should not expect too much from physically disabled people.

strongly agree agree don't know disagree strongly disagree

These statements have been about physically disabled people, what do you understand by the term 'physical disability'?

Appendix III: Pilot Study Questionnaire 2

Thank you for taking the time to complete this questionnaire. All the information will be confidential, the use of your University number is only to make comparison with the first questionnaire possible and the number will be removed before the information is processed.
University Number .....

Please circle the category which most fits your opinion for each of the following statements.

1. Physically disabled people are just as sensible as other people.
strongly agree agree don't know disagree strongly disagree

2. Parents of physically disabled children are less strict than other parents.
strongly agree agree don't know disagree strongly disagree

3. Physically disabled people are usually easier to get along with than other people.
strongly agree agree don't know disagree strongly disagree

4. Most physically disabled people feel sorry for themselves.
strongly agree agree don't know disagree strongly disagree

5. Most physically disabled people worry a great deal.
strongly agree agree don't know disagree strongly disagree

6. Physically disabled people are just the same as anyone else.
strongly agree agree don't know disagree strongly disagree

7. There shouldn't be special schools for physically disabled children.
strongly agree agree don't know disagree strongly disagree

8. You have to be careful of what you say when you are with physically disabled people.
strongly agree agree don't know disagree strongly disagree

9. Physically disabled people are as happy as other people.
strongly agree agree don't know disagree strongly disagree

10. Physically disabled people cannot have a normal social life.
strongly agree agree don't know disagree strongly disagree

11. Severely disabled people are no harder to get along with than those with a minor disability.
strongly agree agree don't know disagree strongly disagree

12. Physically disabled people tend to keep to themselves much of the time.
strongly agree agree don't know disagree strongly disagree

13. Physically disabled people are more easily upset than other people.
strongly agree agree don't know disagree strongly disagree

14. It would be best for physically disabled people to live and work in special communities.
strongly agree agree don't know disagree strongly disagree

15. Most physically disabled people feel that they are not as good as other people.
strongly agree agree don't know disagree strongly disagree

16. It is up to the government to take care of physically disabled people.
strongly agree agree don't know disagree strongly disagree

17. Physically disabled people should not be expected to meet the same standards as other people.
strongly agree agree don't know disagree strongly disagree

18. Physically disabled people are often cross.
strongly agree agree don't know disagree strongly disagree

19. It is almost impossible for a physically disabled person to lead a normal life.
strongly agree agree don't know disagree strongly disagree

20. You should not expect too much from physically disabled people.
strongly agree agree don't know disagree strongly disagree

Do you think that your attitudes towards physically disabled people have changed since you began your training?

Yes No

If **yes**,

In what ways have your attitudes changed?

What has influenced this change in your attitudes?

If **no**,

In what ways have your attitudes remained the same?

Appendix IV: Analysis of Pilot Study Data

The rating scale used:-
strongly agree - 5
agree - 4
don't know - 3
disagree - 2
strongly disagree - 1

The scoring was reverse on the following items:-
2, 3, 4, 5, 8, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20.

summary statistics

Questionnaire 1

n= 71
$\bar{x}$= 75.7
range= 63 - 92
standard deviation= 6.16

Questionnaire 2

n= 73
$\bar{x}$= 77.14
range= 64 - 89
standard deviation= 6.42

Questionnaire 2: divided into 'yes' and 'no' change

yes
n= 43
$\bar{x}$= 76.86
range= 65 - 89
standard deviation= 6.27

no
n=30
$\bar{x}$= 77.53
range= 64 - 89
standard deviation= 6.71

inferential statistics

To see whether there was a statistically significant difference in the two sets of attitude scores a Mann Whitney test between responses to questionnaire 1 and responses to questionnaire 2 was performed:-
U= 2207
U'= 2976
not significant

To see whether there was a statistically significant difference in the responses that could be matched a Wilcoxon test between the matched responses for both questionnaires:-

n= 51

T= 506

not significant

To see whether the respondents who said 'yes' their attitudes had changed did in fact have statistically significant differences between their 2 questionnaires a Mann Whitney test between questionnaire 1 and questionnaire 2 'yes' responses only:-

U= 564.5

U'= 725.5

not significant

To see whether the respondents who said 'no' their attitudes had not changed had statistically significant differences in their responses a Mann Whitney test between questionnaire 1 and questionnaire 2 'no' responses only:-

U= 325.5

U'= 454.5

not significant

To see whether the responses of the 'yes' group and the 'no' group were significantly different their responses to both questionnaires were analyses using Mann Whitney tests:-

Q1 U= 378

U'= 402

no significant

Q2 U= 586.5

U'= 703.5

not significant

It was proposed that respondents in the 'no' group would have more responses the same when the responses to Q1 and Q2 were matched than would the respondents in the 'yes' group. To test this hypothesis the total number of responses the same for each respondent was found and these figures analysed:-

yes	**no**
n= 28	n= 26
$\tilde{x}$= 10.43	$\hat{x}$= 10.58
range= 7 - 15	range= 5 - 17
standard deviation= 2.45	standard deviation= 3.06

Mann Whitney test:-

U= 358.5

U'= 369.5

not significant

Appendix V: Main Study Questionnaire

Thank you for taking the time to complete this questionnaire. The aim of this questionnaire is to find out what you think about people who have a physical disability. The term 'disability' is used in this questionnaire to refer to anyone who has a physical disability.

All the information will be confidential and anonymous, but it would help if you would complete the biographical information at the end of the questionnaire.

[ATDP-A]

a) Please indicate in the box at the left-hand margin how much you agree or disagree with each statement. Please respond to each statement. Put 1, 2, 3, 4, 5, 6 depending on how you feel in each case.

1: I agree very much
2: I agree pretty much
3: I agree a little
4: I disagree a little
5: I disagree pretty much
6: I disagree very much

[ ] 1. Disabled people are often unfriendly.

[ ] 2. Disabled people should not have to compete for jobs with physically normal people.

[ ] 3. Disabled people are more emotional than other people.

[ ] 4. Most disabled people are more self-conscious than other people.

[ ] 5. We should expect just as much from disabled as from non-disabled persons.

[ ] 6. Disabled workers cannot be as successful as other workers.

[ ] 7. Disabled people usually do not make much of a contribution to society.

[ ] 8. Most non-disabled people would not want to marry anyone who is physically disabled.

[ ] 9. Disabled people show as much enthusiasm as other people.

[ ] 10. Disabled people are usually more sensitive than other people.

[ ] 11. Severely disabled people are usually untidy.

[ ] 12. Most disabled persons feel that they are as good as other people.

[ ] 13. The driving test given to a disabled person should be more severe than the one given to the non-disabled.

[ ] 14. Disabled people are usually sociable.

[ ] 15. Disabled people usually are not as conscientious as physically normal people.

[ ] 16. Severely disabled people probably worry more about their health than those who have minor disabilities.

[ ] 17. Most disabled people are not dissatisfied with themselves.

[ ] 18. There are more misfits among disabled people than among non-disabled people.

[ ] 19. Most disabled people do not get discouraged easily.

[ ] 20. Most disabled persons resent physically normal people.

[ ] 21. Disabled children should compete with physically normal children.

[ ] 22. Most disabled people take care of themselves.

[ ] 23. It would be best if disabled persons would live and work with non-disabled persons.

[ ] 24. Most severely disabled persons are just as ambitious as physically normal people.

[ ] 25. Disabled people are just as self-confident as other people.

[ ] 26. Most disabled persons want more affection and praise than other people.

[ ] 27. Physically disabled people are often less intelligent than non-disabled people.

[ ] 28. Most disabled people are different from non-disabled people.

[ ] 29. Disabled persons don't want any more sympathy than other people.

[ ] 30. The way disabled people act is irritating.

[social distance scale]

b) Listed below are a number of activities, using the rating scale

definitely 1
maybe 2
never 3

please put a tick in the box to indicate which you would be prepared to do:-

	1	2	3
work with a physically disabled person	[ ]	[ ]	[ ]
go out with a physically disabled person	[ ]	[ ]	[ ]
share a flat with a physically disabled person	[ ]	[ ]	[ ]
work for a physically disabled person	[ ]	[ ]	[ ]
marry a physically disabled person	[ ]	[ ]	[ ]
vote for a physically disabled person	[ ]	[ ]	[ ]
let a friend or family member marry a disabled person	[ ]	[ ]	[ ]
spend leisure time with physically disabled people	[ ]	[ ]	[ ]
live near physically disabled people	[ ]	[ ]	[ ]

[suitability to train scale]

c) Using the following rating scale

unsuitable 1
probably unsuitable 2
probably suitable 3
suitable 4

please state how suitable or unsuitable you consider the following people are to train as health care professionals [e.g. occupational therapists, physiotherapists, nurses]?

	1	2	3	4
someone who has severe asthma	[ ]	[ ]	[ ]	[ ]
someone who is a wheelchair user	[ ]	[ ]	[ ]	[ ]
someone with a history of schizophrenia	[ ]	[ ]	[ ]	[ ]
someone who is deaf	[ ]	[ ]	[ ]	[ ]
someone with an above knee amputation	[ ]	[ ]	[ ]	[ ]
someone who is 6 stone overweight	[ ]	[ ]	[ ]	[ ]
someone with controlled epilepsy	[ ]	[ ]	[ ]	[ ]
someone with a history of depression	[ ]	[ ]	[ ]	[ ]
someone who is 4'8" tall	[ ]	[ ]	[ ]	[ ]
someone who is partially sighted	[ ]	[ ]	[ ]	[ ]
someone with a facial deformity	[ ]	[ ]	[ ]	[ ]
someone with a history of eating problems	[ ]	[ ]	[ ]	[ ]
someone who is partially hearing	[ ]	[ ]	[ ]	[ ]
someone with controlled diabetes	[ ]	[ ]	[ ]	[ ]
someone who is blind	[ ]	[ ]	[ ]	[ ]

[semantic differential]

d) Please place one cross on each line to indicate how you would describe someone who is physically disabled

e.g.: _:_:_:x:_:_

self sufficient _:_:_:_:_:_ needy
good health _:_:_:_:_:_ poor health
unemotional _:_:_:_:_:_ responsive
clear speech _:_:_:_:_:_ unclear speech
misfit _:_:_:_:_:_ accepted
helpless _:_:_:_:_:_ competent
talkative _:_:_:_:_:_ uncommunicative
valuable _:_:_:_:_:_ worthless
secure _:_:_:_:_:_ insecure
uncontrolled _:_:_:_:_:_ controlled
deceitful _:_:_:_:_:_ trustworthy
misunderstood _:_:_:_:_:_ understood
trusting _:_:_:_:_:_ wary
mature _:_:_:_:_:_ childlike
an asset to society _:_:_:_:_:_ a burden on society
dependent _:_:_:_:_:_ independent
high self esteem _:_:_:_:_:_ low self esteem
will find a job easily _:_:_:_:_:_ won't find a job easily
tough _:_:_:_:_:_ vulnerable
socially inept _:_:_:_:_:_ socially skilled
contented _:_:_:_:_:_ frustrated
insensitive to others _:_:_:_:_:_ sensitive to others
employable _:_:_:_:_:_ unemployable
introvert _:_:_:_:_:_ extrovert
controlled by others/Fate _:_:_:_:_:_ controlled by self
good looking _:_:_:_:_:_ ugly
uncoordinated _:_:_:_:_:_ graceful
physically attractive _:_:_:_:_:_ physically unattractive

e) How old are you? .....

f) Which year of your course are you in?

1st [ ]
2nd [ ]
3rd [ ]
4th [ ]

g) What Fields are you studying? .....

h) Sex female [ ]
male [ ]

i) Tick which box(es) apply to you:

a member of my family has a physical disability	[ ]
I have worked with someone who has a physical disability	[ ]
I have a friend who is physically disabled	[ ]
I know no-one who is physically disabled	[ ]
I myself have a physical disability	[ ]

thank you

Appendix VI: Interview Guides

Interview 1

introduction to the research and series of interviews

consent

background and experience prior to college

'Imagine you are out with a child and you pass a disabled parking space, with the wheelchair symbol, and the child ask you why the space is like that, what would you say?

why do people like that need special spaces?

how would you explain 'disability' to a child?

how would you explain 'why' disability occurs?

why are these people different?

aren't they just the same as you and me?

Think of some one you know who is disabled -
tell me about them ...

how do you get on with them?

how do you feel when you talk to them?

what do you do if they appear to need help?

Scenarios [some situations, explore what you would do]

a) if you found yourself sharing a house with a wheelchair user [e.g., young, woman, paraplegic following RTA, student]
how would you feel?
what would you do if they needed help?
what if they left the place untidy, didn't do the washing up?
what if they needed shopping?

b) you go on Fieldwork and find you are working very closely with a social worker who is blind
how would you feel?
what help would you give?

what would you say to a client who made comments or asked questions about this person?

c) you have a patient, a lady with RA, who you are attempting to do an ADL assessment with, you think she should be able to dress herself, but she refuses

what do you do?

A common response to the questionnaire I gave out was to say how difficult it was to generalise and to answer questions about 'disabled people', why do you think that was?

People were resistant to producing a 'disabled' stereotype and yet in 1501 practically everybody produced a pen portrait of 'Jim', what's the difference?

Do you think your ideas about disabled people have changed since you came to college?

how?

Interview 2

Intro

remind of interview last year,
some of the questions will be the same, not to trip you up but to see if any of your thoughts or ideas have changed

Background:

fieldwork
acceptable modules

Definitions of disability:

last time we talked about how you might define and explain the concept of disability, I'd like to ask you again:

how would you explain disability?

Scenarios:

we talked about a number of scenarios, I'd like to focus on one of them:

you have a patient, a lady with RA, who is in hospital and you are told to assess her, you go along to do a dressing assessment and she says no she doesn't want to get dressed

what do you do

suppose she says she never gets dressed?

In the clinical setting you are often faced with a series of priorities and ideas, your ideas and priorities about a patient, the patient's ideas and the systems,

who's do you think are the most important?

can this cause conflict?

would you fight for your patient's ideas?

ideas about independence:

when you're working with a person, what is your ultimate goal?

what does being independent mean to you?

what might it mean to a disabled person?

If you see a disabled person in the street, shopping in Oxford

what do you think?
how do you respond?

Why did you come into OT?
is this still how you see OT?

You re-did my questionnaire, was it any easier this time?

Do you think your ideas about disability and disabled people have changed since the last interview?
how?
why?

are there any illnesses of conditions that you think 'I really hope that never happens to me?

Interview 3

recap - where was the last Fieldwork Placement?
what acceptable modules have you taken [last term and this term]?

Define disability
also explore concepts of 'normality'

Tell me about some one you know who is disabled

What is your understanding of the 'social model' of disability?
where does OT fit with this model?

OTs are often thought of as having positive attitudes towards disabled people, would you agree with this?
do you think you have a positive attitude towards disabled people?
what does this mean?
do you think this effects your practice as an OT?

scenario - patient with RA, not wanting to get dressed
what would you do?
priorities
needs
problems

which term - 'patient' or 'client'?
what do the terms imply?

what is a successful treatment outcome?
tell me about an intervention which you consider was successful
what determines success?
what determines when the treatment will finish?
how would you feel if a patient/client says 'thank you, you can go now'?

what do you find most satisfying about being an OT?

what would you see as failure or unsuccessful treatment?
tell me about any occasions when treatment was not a success

what does empowerment mean?

reflections on training and the effect on attitudes

APPENDIX VII: QUESTIONNAIRE FOR MODULE 1528

Do you think 1528 has changed your perceptions of people with physical disabilities?

If so, how?

Do you think 1528 has changed your attitudes towards people with physical disabilities?

If so, how?

How did you feel when you realised that some of the members of the module team were disabled?

Did the fact that some of the module team were disabled effect your perceptions of their teaching or their input into the module?

Do you think the idea of 'partnership' with people with physical disabilities has any relevance for you as an OT?

How will your experience and learning on module 1528 effect your behaviour towards people with physical disabilities, whether they are clients or not?

Any other comments?

Thanks for spending the time completing this questionnaire.

APPENDIX VIII: PERSONAL/PROFESSIONAL ATTITUDES QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire.

The term 'disability' is used in this questionnaire to refer to anyone who has a physical disability.

All the information will be confidential and anonymous, but it would help if you would complete the biographical information at the end of the questionnaire.

*Please respond to this questionnaire according to your **professional [personal]** reaction to each of the items.*

Please indicate in the left-hand margin how much you agree or disagree with each statement. Please respond to each statement. Put 1, 2, 3, 4, 5, 6 depending on how you feel in each case.

1: I agree very much
2: I agree pretty much
3: I agree a little
4: I disagree a little
5: I disagree pretty much
6: I disagree very much

1. Disabled people are often unfriendly.

2. Disabled people should not have to compete for jobs with physically normal people.

3. Disabled people are more emotional than other people.

4. Most disabled people are more self-conscious than other people.

5. We should expect just as much from disabled as from non-disabled persons.

6. Disabled workers cannot be as successful as other workers.

7. Disabled people usually do not make much of a contribution to society.

8. Most non-disabled people would not want to marry anyone who is physically disabled.

9. Disabled people show as much enthusiasm as other people.

10. Disabled people are usually more sensitive than other people.

11. Severely disabled people are usually untidy.

12. Most disabled persons feel that they are as good as other people.

13. The driving test given to a disabled person should be more severe than the one given to the non-disabled.

14. Disabled people are usually sociable.

15. Disabled people usually are not as conscientious as physically normal people.

16. Severely disabled people probably worry more about their health than those who have minor disabilities.

17. Most disabled people are not dissatisfied with themselves.

18. There are more misfits among disabled people than among non-disabled people.

19. Most disabled people do not get discouraged easily.

20. Most disabled persons resent physically normal people.

21. Disabled children should compete with physically normal children.

22. Most disabled people take care of themselves.

23. It would be best if disabled persons would live and work with non-disabled persons.

24. Most severely disabled persons are just as ambitious as physically normal people.

25. Disabled people are just as self-confident as other people.

26. Most disabled persons want more affection and praise than other people.

27. Physically disabled people are often less intelligent than non-disabled people.

28. Most disabled people are different from non-disabled people.

29. Disabled persons don't want any more sympathy than other people.

30. The way disabled people act is irritating.

How old are you? .....

Which acceptable module did you study this term?

1528 [ ]
1261 [ ]
1918 [ ]

Sex female [ ]
male [ ]

Tick which box(es) apply to you:

a member of my family has a physical disability [ ]
I have worked with a colleague with a physical disability [ ]
I have a friend who is physically disabled [ ]
I know no-one who is physically disabled [ ]
I myself have a physical disability [ ]

APPENDIX IX: SOCIAL DISTANCE QUESTIONNAIRE

Disability Social Distance Scale

There are many degrees of understanding or closeness that may exist between people. Nine of these relationships are listed below in order of closeness, with number 1 describing the closest relationship and number 9 the most distant relationship.

1	2	3	4	5	6	7	8	9
would marry	would accept as a close kin by marriage	would have as a next door neighbour	would accept as a casual friend	would accept as a fellow worker	would keep away from	would keep in an institution	would send out of my country	would put to death

Which item on the above scale best describes the closest relationship you feel toward each disability group listed below? Next to each disability place the number of the item on the scale that describes the closest relationship you would be willing to have with a person with such a disability.

_____Alcoholism	_____Deafness	_____Mental handicap
_____Amputee	_____Diabetes	_____Mental illness
_____Arthritis	_____Dwarf	_____Old age
_____Asthma	_____Epilepsy	_____Paraplegic
_____Blindness	_____Ex-convict	_____Stroke
_____Cancer	_____Heart disease	_____Tuberculosis
_____Cerebral Palsy	_____Hunchback	_____Ulcer

Please complete the following demographic information, to assist with the analysis of this data:

Year of study: 1 2 3 4

Field/s of study:_____

age:_____

sex: male female

thank you for completing this questionnaire